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**Patients' Experiences of Psychiatric
Intensive Care - An Interpretive
Phenomenological Analysis**

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**A doctoral project report submitted in partial
fulfilment of the requirements of Sheffield
Hallam University for the degree of
Professional Doctorate Health and Social Care**

September 2013

ABSTRACT

Psychiatric intensive care is for patients who are compulsorily detained and are in an acute phase of a serious mental disorder. They have a loss of capacity for self-control, an increase in risk of aggression, suicide and self-harm. This compromises the physical and psychological wellbeing of themselves and others and does not enable their safe, therapeutic management and treatment in a general open acute ward. Psychiatric Intensive Care Units (PICUs) are small, highly staffed wards that provide intensive treatment to reduce risk, disturbance and vulnerability. They are open plan and may have seclusion facilities. Being cared for in a PICU can be a difficult, distressing and stressful time for patients, their family and carers and also provides one of the greatest challenges for the clinical staff caring for them.

There is very little evidence and understanding about what it is like to experience this intensive care and an absence of research that examines patient perception and satisfaction with services. In light of this, the aims of this project are to illuminate patients experiences of psychiatric intensive care, to initiate an understanding of what it is like to be cared for in PICU and to explore the meaning that patients ascribe to their experiences of psychiatric intensive care.

This project is an interpretive phenomenological analysis (IPA) of the accounts of patients receiving psychiatric intensive care. IPA is an approach to qualitative research that aims to offer insights into how a given person, in a given context, makes sense of a given phenomenon. Usually these phenomena relate to experiences of some personal significance, in this instance the episode of care in a PICU. Supported by the Trust Service User and Carer Research Group, this study undertook observations of patients during the time they spent on a PICU and once transferred to an open ward, four patient interviews were carried out. The findings have contributed to the existing literature regarding psychiatric intensive care.

A number of implications for practice were identified, including the emotional wellbeing of patients distinct to their mental distress, the nature and impact of sedation, seclusion and care interventions and finally, the role and function of the [changeable] ward community.

ACKNOWLEDGEMENTS

My project would not have been possible without the four participants who all agreed to take part in this research and give their time. I am grateful for their contribution and insights into their experiences at a stressful and distressing time in their lives.

I would also like to thank my supervisors for their time and patience, the Trust for all the time and support provided to me and to the team I work with for encouraging me to continue and for offering thoughts and considerations on my drafts.

To my friends and family, thank you for putting up with my absences and finally to Tom and the boys for all your patience and tolerance - Thank you.

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'L'écriture est la peinture de la voix.'¹

- Voltaire

¹ 'The writing is painting the voice' - Voltaire

Chapter 1 - Introduction

As a student nurse in a small county asylum the provision of acute mental health care that I experienced was carried out on a small number of locked acute wards. The wards, structured by which area of the county a patient came from, were locked at the discretion of the ward sister and dependant on whether anyone was wishing to leave, irrespective of whether they were detained or not. Whilst there was no intensive care² provision, there were two secure 'side rooms'³ near the main ward area. The provision of two side rooms seemed the same on all wards, regardless of size, layout or occupancy. The care and management of distressed and disturbed patients took place anywhere within the ward; however, the requirement for this was relatively infrequent.

Following qualifying as a registered nurse in 1987 I moved to an acute mental health unit attached to a District General Hospital. The role and function of the 'side rooms' continued, with an increase in the number of side rooms from two to seven. The frequency of the use of these seven side rooms was much greater, and this increase was immediately apparent. I found this public display of physical restraint and seclusion⁴ distressing for the patient⁵ and my involvement, both as a witness and in participation, shocking.

² As described in chapter two, at this time there was no clear definition of intensive care. Here it is taken to mean specific provision for acutely distressed and disturbed patients who present a risk and their safe, therapeutic management and treatment is complex and challenging.

³ A definition of a 'side room' is difficult to establish. However it was a commonly used term on acute mental health adult wards. On these wards there were usually several 4 or 6 bed bays for patients. In addition, each ward also had a number of single rooms. These rooms were referred to as the 'side rooms' and were used when a patient was extremely unwell, distressed and disturbed in order to provide more close nursing and medical care.

⁴ Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others (DH 2008a, p. 122 paragraph 15.43).

The focus of the ward was often around the row of side rooms which is where all activity took place. Little freedom, dignity or respect was afforded to those acutely unwell, distressed and disturbed. Care was chaotic and fragmented.

In the mid 1990s a small area of one ward was partitioned off to create an intensive care area⁶. This was a key move in terms of privacy and dignity; despite this, the approaches used to manage and contain disturbed and distressed patients did not differ, and it simply took place behind a closed door.

When I returned to the same unit as the Modern Matron five years later I was in a position to have greater influence on the strategic development of care delivery. This coincided with the publication of the '*Adult Acute Inpatient Care Provision: Mental Health Policy Implementation Guide*' (DH 2002a) and the '*Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in PICU and Low Secure Environments*' (DH 2002b). During this time I was able to influence the provision of social and therapeutic activities on the unit and also to improve the environment of the PICU and re-structure how care was provided.

I also spent time on secondment as the North East, Yorkshire and Humber regional acute care programme lead for the Care Services Improvement Partnership/ National Institute for Mental Health in England (CSIP/NIMHE).

⁵ It remains unclear whether terminological use is important to the people who use mental health services (Dickens and Picchioni 2012). For those who hold a strong view, increasingly the literature identifies that 'patient' is the preferred term (Simmons et al 2010). This is supported by Dickens and Picchioni (2012) who identify that the favoured terms of those who use mental health services to describe themselves are either 'patient' or 'client'. Therefore for the purpose of this project the term 'patient' is used throughout with the exception of the references to the Trust Service User and Carer Research Group. Here given that this is their formal title the term service user will be respected and maintained.

⁶ This was a small area of the ward that was altered to provide a more secure, private area for those experiencing the most acute mental health distress.

The significance of this was that my role included taking the lead across the region supporting local services to implement and put into practice Department of Health and NIMHE national priorities and strategies. I was acutely aware of the need to understand these initiatives and priorities from a patient's perspective.

At this time the Trust was successful in securing national funding to develop a newbespoke PICU and Section 1367 suite within the Trust and I provided the clinical lead to this developmental work. It was seen as a ground-breaking example of good practice for the environment and delivery of intensive care.

At the commencement of my Doctoral studies I was a newly appointed Nurse Consultant in Adult Acute Mental Health Inpatient Services for the Trust. During the course of my Doctoral study my role changed to that of Deputy Director of Nursing. This has provided a different focus for my professional role in that it is Trust and Service wide; however, the central focus of this research project, to understand healthcare from the perspective of patients, remains relevant in terms of method, outcome and impact in service delivery and development.

'You never really understand a person until you consider things from his point of view - until you climb into his skin and walk around in it' -
Atticus (Lee 1960)

Section 136 MHA 1983 : mentally disordered people found in public places

Under Part Ten of the Mental Health Act 1983, Section 136 allows for the removal to a place of safety of any person found in a public place who appears to a police officer to be suffering from mental disorder and to be in immediate need of care or control or for the protection of others. The purpose of removing a person to a place of safety is to enable the person to be examined by a doctor and interviewed by an AMHP, so that the necessary arrangements can be made for their care and treatment. The maximum period a person may be detained under section 136 is 72 hours. Good practice indicates that local policy would identify a suitable place of safety and whilst this may be the police station or a general hospital, should the need arise; the most preferred place is a dedicated Section 136 suite.

The most profound book I read as a child was 'To Kill a Mocking Bird' written in 1960 by Harper Lee. I referenced it during my student nurse interview in an attempt to demonstrate how I viewed the world at the age of 17. The above quote from Atticus in Chapter three has remained with me throughout my nursing career. Whilst the concept of empathy and an empathic approach to caring for people today may be a more sophisticated approach than the one Atticus illustrates, for me his sentiments still hold true. Particularly when attempting to understand other people's experiences in such a way that we can support them during times of acute and disturbing mental health distress.

Acute mental health distress and the requirement to be cared for in a Psychiatric Intensive Care Unit (PICU) is one of the most profound experiences possible within mental health [and one of the most challenging in which staff provide care] therefore the question I pose to myself and others is 'how can we as caregivers start to comprehend the enormous experiences that face a patient during this time?', equally 'how can we then possibly provide the highest level of compassionate care?'

Care may be delivered compassionately through the use of the skills and experiences that are already known – for example, sensitivity, empathy, kindness and personalised care. However, to truly be compassionate, we need a greater understanding of what it is like to be in that person's shoes, to 'climb into [their] skin and walk around in it'.

This doctoral project report is divided into five chapters. This first chapter has provided an introduction to my motivation to undertake this project and also outlines the remainder of the project.

Chapter two is divided into three sections. Firstly the history, role and purpose of psychiatric intensive care are described. In particular the absence of a structured approach to the development of psychiatric intensive care is described. Also included is the national context of acute mental health care and Psychiatric Intensive Care Units (PICUs) together with the policy framework that supports PICUs.

Secondly, previous research into the care provided across acute mental health care and PICUs is explored, identifying the role of patient feedback on services received. This also includes a more detailed account of my motivation for undertaking this project and a discussion regarding the relevance and importance of the research I propose. The chapter concludes with the third section that details the aims of this project and my research question.

Chapter three moves from the background and foundation of the project, to an exploration of the chosen methodology. Firstly the rationale of the four proposed elements of the research project is described before the process for selecting a qualitative approach and specifically the choice of Interpretive Phenomenological Analysis (IPA) is presented. Following this the project design and structure are outlined.

The chapter then describes the ethical considerations and approach to quality undertaken within the project. In particular, the requirement for a sensitive approach to patients in an acute phase of their mental health and how this is attended to within the project. Finally the role and impact of the Trust Service User and Carer Research Group is described including the structure of the observation sessions within the PICUs.

Chapter four presents the analysis and findings from both the observation phase and interview phase of the project. The chapter then describes the on-going engagement with the Trust Service User and Carer Research Group and my reflections, the limitations and benefits of this phase of the project. Finally through six identified master themes, the chapter details the findings of the interview phase of the project.

Chapter five presents a discussion of the findings from the analysis. This discussion is underpinned by the master themes that I consider are most relevant to the advancement of intensive care and clinical practice. Similarly it is those master themes where I believe the patient voice can be most heard and have an influence in developing practice.

In the absence of literature relating specifically to patients experiences of psychiatric intensive care, this section draws on other work and literature whereby parallels could be identified to illuminate the as yet unexplored experiences of patients during the time they spend in PICU. From here this chapter describes the significance of the study, the implications for practice and methodological considerations, including limitations to the study, before making recommendations and identifying areas for future research. My reflections on the study are explored, including plans for the dissemination of the study and findings.

This chapter concludes with a summary of the whole project. Through exploration and examination of the meaning that patients ascribe to their experiences of psychiatric intensive care, six key areas were identified that illuminate patient experience:

- Patient's experiences of psychiatric intensive care are frightening and prompt strong emotional responses.
- Some patients do not recall specific events, however, all recollect the distressing emotions attached to being cared for in PICU.
- Patients have differing experiences of the relationships developed between themselves and also with staff during the time they spent in PICU.
- That a calm environment in PICU can evoke a feeling of fearful apprehension in patients.
- That witnessing other patients restraint leaves patients apprehensive about what will happen to them.
- Patients experience separation from their families, home and usual environments and this impacts on how they view themselves and their own identity.

A greater understanding of how patients feel about their care that is provided within a PICU has been uncovered. This has supported recommendations for improving practice and care delivery in a way to enhance patient experience.

Chapter 2 - Background

2.1 Overview

This chapter is divided into three sections. Firstly the history, role and purpose of psychiatric intensive care are described. This includes the national policy context of acute mental health care and Psychiatric Intensive Care Units (PICUs) and is the commencement of the review of literature relating to psychiatric intensive care and PICUs. Secondly, previous research into the care provision within acute mental health care and Psychiatric Intensive Care Units (PICUs) is explored, identifying the role of patient feedback on services received. Collectively the first two sections provide the rationale for this project and support the aims and research question identified in section 2.4.

The literature reviewed throughout this chapter identifies a gap in existing knowledge and provides justification for the research question and aims (Cronin et al 2008). Equally it supports this project to provide a voice for those not heard in the literature (Creswell 2007), in this case patients who experience acute mental health distress and require care in a PICU.

This chapter focuses on work specifically with regard to adult mental health care and psychiatric intensive care and provides a contextual literature review for the project; through the research undertaken within this project and discussion of the findings in Chapter five, new areas of previous work have been identified. Therefore through an organic and iterative process additional literature and knowledge are brought into the arena when considering patients experience of the care they received within PICU.

2.2 Psychiatric Intensive Care

History

PICUs do not appear to have a structured, purposeful history. There is no clear detailed narrative with regard to the development of PICUs (Bowers et al 2008). Historically most mental health hospitals were locked regardless

of the status of patients. The concept of patients being admitted informally was introduced in the Mental Treatment Act 1930 (Beer et al 2008), where voluntary admission was allowed (Cope 1995) and '*voluntary patients were encouraged*' (Turner et al 1999 p. 578). This was further strengthened by the Mental Health Act 1959 where informal admissions were encouraged (Cope 1995).

Further impetus to change the way in which mental health care was organised also began at this time. Occupancy rates and the number of mental health inpatient beds decreased greatly (Boardman 2005). Whilst there was a peak of over 150,000 beds in England in 1955, a decrease to 42,000 in the period 1994-1995 (Ford et al 1998) was observed. Further reduction over the next decade resulted in there being only 32,400 mental health inpatient beds remaining by 2003-2004 (DH 2004). Despite the fall in overall bed numbers, the number of admissions per year has increased from 207,000 in 1984 to 237,000 in 1994-1995, representing a significant increase in throughput per bed each year (Ford et al 1998).

There are differing perspectives on how the history of psychiatry may be viewed, including the influence of new treatments (Lakeman 2013) and consequently the impact on bed numbers and locked wards. One of these developments was the introduction of a new range of psychopharmaceuticals, starting with Chlorpromazine and followed by a number of other drugs (Moncrieff 2013).

The introduction of Chlorpromazine in the late 1950s was seen as one of the greatest advancements in psychiatric care and that its introduction dramatically improved the prognosis of patients cared for in psychiatric hospitals (Moncrieff 2013). The arrival of Chlorpromazine, among other medications, is described both as a major development in psychiatry (Moncrieff 2013) and as a miracle cure (Ban 2007; Lakeman 2013). Equally the availability of antipsychotic drugs was also seen as transforming disturbed wards and psychiatric services (Ban 2007) and consequently resulted in a significant reduction in the number of locked

wards (Beer et al 2008). Further perspectives are that the impetus to move patients out of the large mental health institutions existed prior to the development of the new range of drugs, including Chlorpromazine and claims that medical treatments influenced the volume of discharges are not substantiated (Boardman 2005).

In spite of the differing opinions regarding the cause, it is clear that there were more patients who could be cared for on open wards and subsequently within the community and Boardman did concede that drug therapy did play an important role (2005).

An outcome of this was that there were a small number of wards that remained locked. Here patients who were either chronically disturbed or who were transiently acutely disturbed for a short period of time were cared for (Beer et al 2008). This view that such wards cared for a mixed population of disturbed patients is further supported by Bowers et al where it is identified that these wards:

'were taking episodically difficult patients from the long-stay wards as well as from open acute units. They may even have had a smaller group of patients whose disturbance was more ingrained and continuous, and who could not be coped with elsewhere within the hospital'

(2008, p. 56)

Bowers et al (2008) identified that pleasant wards were at the top of the system and the disturbed wards at the bottom. Whilst potentially at the bottom of the system, the *'Psychiatric Intensive Care Unit'* function had evolved to be a pragmatic solution to the issue of the open wards for those who were either transiently or chronically disturbed (Beer et al 2008).

Psychiatric intensive care was first recognised as a concept of care delivery in the early 1970s (Crowhurst and Bowers 2002). One of the first users of the term psychiatric intensive care was Rachlin (1973). He produced a paper analysing the need for a closed ward, situated in an

open hospital, to treat several types of patients who did not respond to open wards (Crowhurst and Bowers 2002).

During this period a working party was established by the Department of Health and Social Security to review existing guidance on security in Psychiatric Hospitals (Beer et al 2008). As a result the Glancy report was published in 1974. The focus of this report was on security in NHS hospitals. Both this and the interim report of The Butler Committee, that also reported in 1974, recommended that secure provision should be made available for the treatment of mentally disordered patients who required greater security than could be provided in a standard hospital setting (Mayor et al 1990).

The closure of large asylums in the 1980s led to the smaller, locked wards not being accessible for the patients that required a higher level of care. As such new wards were being opened in the psychiatric units attached to general hospitals (Ford and Whiffin 1991). Here confusion arose regarding the role, nature and function of PICUs with regard to the admission of forensic patients. This is particularly related to patients who require a low level of security or who require rehabilitation from special hospitals (Beer et al 2008).

It was also identified that some PICUs do not consider themselves as forensic units and are reluctant to admit restricted⁸ patients (Dix 1996). This confusion is further referred to when describing later surveys on the provision of psychiatric intensive and low secure care. However, at this point in the history of PICUs strengths and weaknesses of mixing the two

⁸ A restricted patient is someone detained under Part 3 of the Mental Health Act 1983, who, following criminal proceedings is made subject to a restriction order under section 41 of the Act, to a limitation direction under section 45A or to a restriction direction under section 49. The order or direction will be imposed on an offender where it appears that it is necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that restricted patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice and only the Tribunal can discharge them without the Secretary of State's agreement (DH 2008).

were described, (for example: Cripps et al 1995; Beer et al 1997; Pereira et al 1999) and the most dominant feature of PICUs was seen as accepting patients briefly, to get them over an acute disturbance, before returning them to the original ward (Faulk 1995). This definition holds true for many PICUs and specifically for the two PICUs that are the focus of this project.

Through the 1990s PICUs have developed independently of the Regional Secure Unit (RSU) network, developing a diverse range of services in line with local availability and need (Beer et al 2008, Bowers et al 2008).

Both during and since that time there have been a number of attempts to define and describe PICUs; one such definition is that PICUs are:

'Small wards with higher levels of nursing and other staff, built on an open plan design to ease observation, and often (but not always) locked, and sometimes (but not always) have facilities for seclusion'

(Bowers et al 2008, p. 57).

A number of authors (for example Beer et al 1997, Crowhurst and Bowers 2002, Bowers et al 2008) have proposed that there is no clear consistent definition of [what constitutes] a PICU. All these authors identify that PICUs vary in terms of bed numbers, staffing levels, admission criteria, environment, care and treatment, admission of women, supervision and training and the placement of intensive care in the overarching philosophy of acute care provision.

Despite this, PICUs are now a standard part of United Kingdom (UK) mental health care (Brown et al 2008). As is described later, subsequent national policy and guidance of the provision of psychiatric intensive and low secure care has ensured it is an established option for the care of acutely disturbed and distressed people.

The role and purpose of psychiatric intensive care

Mental health is a part of everyone's daily life. There are many views and descriptions of what constitutes mental health and wellbeing; despite the diversity of views; there is broad agreement regarding the prevalence of mental health problems within the general population. In spite of the difference in views about what constitutes mental health, the Department of Health (DH) identify that one in six people of working age will, at any time, have a mental health problem (DH 1999). The Office for National Statistics Psychiatric Morbidity supports this with the claim that one in four adults experience at least one diagnosable mental health problem in any one year (Mental Health Foundation 2009).

The role, function and purpose of acute mental health inpatient care is not properly understood. It is not explicitly defined in government policy, mental health legislation, local policies or mental health texts (Bowers et al 2005). Therefore definitions regarding acute care for those actually delivering care are few.

A conceptual model of the aims of acute mental health inpatient care has been described by Bowers et al (2009). This model identifies three categories that articulate acute care:

- Admission criteria.
- Function of the admission.
- The functions of inpatient care.

When a person requires care for a mental health issue or concern they will generally receive treatment in the community (National Audit Office 2007), However, when it is identified that a person poses a risk to themselves or to others, or that they require further assessment, specific treatment, or in some instances respite for both themselves and for their carers they may require a period of inpatient care.

The nature and reason for admission to a mental health ward has evolved over the years. The reduction in bed numbers as a consequence of the closure of the large institutions in the 1980s (Hardcastle et al 2007) and further policy changes over the past 10 years has resulted in the type of patients receiving inpatient care changing to those who are most ill, vulnerable, disturbed and posing a risk to workers and the communities in which they live (Bowles and Howard 2003). To further support this, Bowers (2005, p. 231) has carried out a structured review of admission criteria and identified that it fell into seven categories:

- Dangerousness.
- Assessment.
- Medical treatment.
- Severe mental disorder.
- Self-care deficits.
- Respite for carers.
- Respite for the patient.

The Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision (DH 2002a) provides the most contemporary clear definition; here it describes succinctly the purpose and leaves the achievement of the purpose to the detail of care delivery.

'The purpose of an adult acute psychiatric inpatient service is to provide a high standard of humane treatment and care in a safe and therapeutic setting for patients in the most acute and vulnerable stage of their illness. It should be for the benefit of those patients whose circumstances or acute care needs are such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restrictive residential setting'

(DH 2002a p. 5)

Due to the development of community services for mental health in terms of Community Mental Health Teams (CMHTs), assertive outreach teams and more specifically crisis and home treatment teams for those experiencing lower levels of acute distress or crisis, it is usually only when

people are most seriously ill that they are admitted to an acute care ward. This has, over recent years, increased the complexity of patients on wards, with concerns around substance use, lack of housing or community provision, and significant social hardship worsening this complex clinical picture (Bowles and Howard 2003).

It is during this acute mental health breakdown that patients may, through either deterioration of their symptoms and behaviours or through assessment regarding their own or others safety; spend some time being cared for in a Psychiatric Intensive Care Unit. Here patients receive more intensive care, input and security than they would ordinarily receive on an open acute mental health admission ward.

A definition of the care received in a PICU was provided with the publication of the Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in PICU and Low Secure Environments (DH 2002b). Here psychiatric intensive care is defined as:

'For patients compulsorily detained, usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a general open acute ward'.

(DH 2002b, p. 3).

As psychiatric intensive care develops as a speciality in its own right, further definitions of what this care consists of and what constitutes a PICU are starting to emerge (Beer et al 2008). Beer et al (2008) identify three features that they suggest should be present in all PICUs. The first restates the definition given in the policy implementation guide (DH 2002b) and outlines the environment and resources that make up intensive care. The second describes the intensive level of care required and the expertise staff should have or develop and the third identifies the importance of an agreed philosophy of care underpinned by risk assessment and management (Beer et al 2008).

More recently the Department of Health (2012a) published a consultation on the commissioning of psychiatric intensive care. This consultation provides further descriptions of psychiatric intensive care. They are comparable to those provided by Beer et al (2008), in that PICUs are small, highly staffed wards, they provide intensive treatment that is a combination of physical, procedural and relational security measures aimed to reduce risk, disturbance and vulnerability (DH 2012a). The consultation also gives more detail on the anticipated behaviours of patients who are admitted to PICUs. Such patients are described as those who:

- Display acute behavioural disturbance that seriously compromises the physical and/or psychological wellbeing of themselves and/or others.
- Present a notable risk of aggression, suicide and/or serious self-harm.
- Are at risk of increased vulnerability because of sexual disinhibition or over-activity in the context of mental disorder.

Further, the DH (2012a) consultation identifies that following treatment in the PIC [PICU], patients are likely to continue to receive inpatient treatment in other ward settings. In the context of this project this is a key component of their journey of care.

The DH consultation identifies that the PICU should also provide care and treatment for more vulnerable patients, identifying the physically frail or those with dementia (2012a). This appears to be an aspiration for the future and falls out of the scope of this project, nonetheless, the findings of this project may support services in determining how they may tackle the issue of providing intensive care to all sections of mental health care requirements and not just for adults of working age.

The collective description and discussion regarding the types of care and patients admitted to PICUs demonstrates the potential for these patients to

lack capacity and judgement; this is described later when discussing the role of patients in feedback and also research methodologies.

National context of acute mental health care and PICU

During the 1980s the focus of mental health care moved away from hospital settings to community provision. Whilst community care was slow to develop (West 2003) there was an on-going rise in the demand for people to be admitted to inpatient mental health wards. This was combined with inpatient services being neglected due to service development and research being focused on alternatives to inpatient admission (Bowers et al 2009).

Therefore [neglected] acute psychiatric wards took the full brunt of meeting this increasing demand for inpatient care (West 2003). This rise in demand continued in the 1990s. This demand and increased acuity is evidenced in a survey carried out jointly by the Mental Health Act Commission in collaboration with The Sainsbury Centre for Mental Health (SCMH 1997), where detained patients in a few wards accounted for up to 100% of admissions, and on the '*vast majority of wards*' up to 50% patients were detained (SCMH 1997 p. 10).

The increase in demand, lack of focus and resources resulted in an emerging body of recognition of the poor standards of care on acute mental health wards (for example, Ford et al 1998; Sainsbury Centre for Mental Health 1998; Standing Nursing and Midwifery Advisory Committee 1999; MIND 2004; "Rethink" 2004). The Royal College of Nursing (RCN 1998) identified that there was growing evidence to suggest that mental health acute inpatient services were being stretched to the limit and were unable to meet minimum standards of care. The report also went on to identify that services were understaffed and were both unsafe and not therapeutic. Serious problems about the process of care such as the impact of emergency admissions were also being reported (Higgins et al 1999). This included the lack of contact between nurses and

patients, which became a common phenomenon as further evidence emerged (for example, Ford et al 1998; Sainsbury Centre for Mental Health 1998; Standing Nursing and Midwifery Advisory Committee 1999; MIND 2004; "Rethink" 2004, CQC 2009).

Service user perspective

During the late 1990s patient organisations were focusing their energies on inpatient care, in particular the Sainsbury Centre for Mental Health, "Rethink" and MIND.

In 1998 the Sainsbury Centre for Mental Health published the first and most significant of a number of reports, *Acute Problems - A survey of the quality of care in acute psychiatric wards* (SCMH 1998). Here they carried out a major piece of research following over 200 patients through their experience of inpatient care. One of the key aims of the project was to develop a picture of life on acute psychiatric wards.

Within the methodology no reference is made about what type of wards the patients were selected from. Therefore no distinction can be made whether they are patients from open wards or PICUs or both. This may not be significant, as a further study carried out a comparison of PICU patients with open acute ward patients and found no differences (Whykes and Carroll 1993). This study by Whykes and Carroll (1993) was identified by Bowers et al (2008) as being the only study within a PICU that sought patient's perspectives (Bowers et al 2008).

The Sainsbury Centre for Mental Health report, *Acute Problems - A survey of the quality of care in acute psychiatric wards* (SCMH 1998) was very critical of inpatient services; however, several key areas that were important to patients were highlighted. These are summarised in Figure 1. Surprisingly the report also stated that:

'Most patients leave acute care in a better mental state than when they came in'.

(SCMH 1998 p. 5)

Summary list of key areas from Acute Problems:

1. Inpatient care is unpopular.
2. Wards lack basic amenities:
 - a. Few single rooms.
 - b. Few secure lockers.
 - c. Generally no quiet areas.
3. Patients feel unsafe.
4. Women are concerned about privacy, cleanliness and personal safety.
5. Conditions are poor.

(SCMH 1998)

Figure 1: Key areas important to patients (SCMH 1998)

In 2004 'Rethink', 'Sane' and the Zito Trust collectively embarked on a report of their own outlining the state of adult acute inpatient care. Their report 'Behind Closed Doors' ('Rethink'2004) sought to highlight poor conditions and care delivery. Indeed it presents many issues already known (Figure 2) but does not seek to balance this with work previously undertaken, for example, the Adult Acute Inpatient Care Provision: Mental Health Policy Implementation Guide (DH 2002a); the Mental Health PolicyImplementation Guide: National Minimum Standards for GeneralAdult Services inPsychiatric Intensive Care Units (PICU)and Low Secure Environments (DH 2002b).

The 'Rethink' (2004) report describes in detail worrying conditions (see Figure 2) but does not indicate the source of the information nor substantiate its findings. Whilst they are not so removed from that of the Sainsbury Centre or MIND, they do not offer anything new in terms of problem or solution.

The way forward identified in the 'Rethink' (2004) report is a reiteration of a definition of a quality mental health service identified by the then Government National Director for Mental Health, Professor Louis

Appleby, four years previously. Here Appleby (2000) wrote an editorial in the British Journal of Psychiatry identifying six key elements that a quality service should have. The 'Rethink' report restated them in full. Given the four intervening years it is a concern that, despite the National Service Framework for Mental Health being half way through its 10 year life and several significant policy foci on acute mental health wards, no impact in terms of improvements were being felt or perceived by patients and their supporting bodies.

A summary of patient reported concerns:

1. A poor physical and psychological environment, (safety, privacy, dignity and comfort).
2. Insufficient information.
3. Lack of involvement and engagement in their own care and in how the ward is run.
4. Inadequate staff contact, particularly on a one-to-one basis.
5. Insufficient attention to the importance of factors like ethnicity, gender and protection from harassment/abuse.
6. Lack of 'something to do,' especially activity that is useful and meaningful to recovery.

(‘Rethink’ 2004)

Figure 2: Patient concerns (‘Rethink’ 2004)

At a similar time to the 'Behind Closed Doors' report MIND launched their Ward Watch campaign. Here they sought to obtain patients views on hospital conditions for mental health patients. The resulting report is not subject to any external review and does not describe their methodology in any detail; they have managed to elicit direct patient views and perceptions on how things are within acute mental health wards for those being cared for within them. MIND highlight key findings outlined in Figure 3.

The key factors common to these three pieces of work, regardless of their differing pedigrees in respect to robustness, is that of patients feeling safe, the provision of dignified and gender sensitive care and the physical environment.

A summary of the key findings from MIND (2004):

1. 23% of recent and current inpatient respondents have been accommodated in mixed sex wards.
2. 31% of respondents did not have access to single sex bathroom facilities. Only 30% of respondents had access to single sex daytime facilities.
3. 27% of respondents said that they rarely felt safe while in hospital.
4. 51% of recent or current inpatients reported being verbally or physically threatened during their stay with 20% reporting physical assault.
5. 18% of respondents reported sexual harassment in hospital.
6. 7% respondents reported being subject to harassment because of their race.
7. 10% of respondents reported being subject to harassment because of their sexuality.
8. 56% of harassment or assault episodes were perpetrated by patient on patient.
9. 53% of respondents thought that the hospital surroundings had not helped their recovery. 31% thought that it had made their health worse.
10. 20% of respondents felt that they were treated with respect and dignity by staff. Almost the same proportion (17%) stated that they were never treated with respect and dignity by staff.

Figure 3: MIND's key findings (MIND 2004)

Simultaneous to the patient movement and charitable organisations, that focus on mental health services, providing clear evidence to the poor levels of care and dissatisfaction with services, there was recognition nationally of the need to do something about the standards of care.

It was identified that a premise of the NHS Plan (DH 2000) was to strengthen community care, and in doing so, to take the pressure off acute mental health beds. Unfortunately, by developing community services the *focus*, rather than the *pressure* was taken off beds. This, combined with an absence of patient feedback on the quality of services provided within acute mental health care and an absence of true understanding of the nature, role and purpose of acute mental health care has resulted in it continuing to be a 'black box' with patients admitted and then discharged

with very little known about what *happens* whilst they are there (Quirk and Lelliott 2001).

To underline this, in 2002 Matt Muijen, the then Chief Executive of the Sainsbury Centre for Mental Health, when describing acute mental health inpatient wards, wrote:

'It would be surprising if a public service was tolerated when it was feared by its customers, who are put at risk; unable to show evidence of its effectiveness; very expensive; and paying its staff uncompetitively. It would be astonishing if, nevertheless, such a service could not cope with demand. This is a recognisable picture of acute hospital care in the NHS.'

(2002, p. 342).

In 2002 two key Policy Implementation Guides for mental health were published.

Firstly, the Adult Acute Inpatient Care Provision: Mental Health Policy Implementation Guide (DH 2002a). This guide is primarily concerned with identifying current problems with inpatient care, providing guidance on reshaping and developing services, and integrating inpatient care within a whole system approach. What is of greatest importance to this project is the desire that the philosophy of care should be 'explicitly user focused' (DH 2002a). In addition the policy implementation guide sought to ensure each ward established a means of dialogue between the staff and those receiving care (Rae and Rooney 2003).

Secondly, and more specifically the Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments (DH 2002b) was published. As a clinician I had great anticipation of this guidance and indeed it provided a significant amount of direction for the provision of services, in particular the environmental, structure and process of care delivery within PICUs. It also identified patient involvement in the process, the running of and development of services. However, where it

falls down is in capturing the experiences of being cared for within a PICU environment.

In 2008, following an extensive national consultation process Lord Darzi published the NHS Next Stage Review Final Report. The report outlined a vision of the NHS with quality at the heart of all that it does (Darzi 2008).

When reviewing both the national report and Healthy Ambitions, the Yorkshire and Humber Strategic Health Authority next stage review of the Darzi report, the focus is seen to be on primary care, access to services and community mental health services. Whilst this is laudable and extremely important, little regard is given to those suffering from a psychotic illness⁹ and in particular those from acute distress and disturbed behaviour. Again these people appear to remain invisible to the policy makers.

Perhaps one reason for this is that these views are inherently and historically difficult to obtain and have been subject to discredit. There has been history of the voices of mental health service users being 'less privileged' than others (Hopkins and Niemiec 2006) and that they do not know their own mind or are unrepresentative, especially if articulate (Goodwin et al 1999). In particular it was identified they are unable to give reliable and valid feedback about services (Lovell 1995).

One aim of this project is to seek the views of those experiencing acutely disturbed behaviour and that require the most intensive mental health care and demonstrate that their views may provide legitimate feedback on the quality of their experience.

As part of improving the quality of NHS care the Health Bill 2009 introduced Quality Accounts (DH 2009a). All healthcare providers were, from April 2010, required to publish their 'Quality Accounts'. These

⁹Psychosis is a group of severe mental health disorders (NICE 2011), characterised by loss of touch with reality which may manifest as hallucinations, delusions, bizarre behaviour and disorders of thought (Okocha 2008).

are reports to the public on the quality of services they provide in every service line - looking at safety, experience and outcomes, highlighting that 'For the first time, patients' own assessments of the success of their treatment and the quality of their experiences will have a direct impact on the way hospitals are funded' (Darzi 2008, p. 12).

As previously indicated, the Darzi review demonstrates a disappointing absence of any reference to acute inpatient mental health services. It seems a shame that again those in acute distress do not get the focus they deserve. Peter Carter (General Secretary of the Royal College of Nursing) when commenting on the Darzi review stated that The overwhelming majority of NHS care is safe, but we believe the ambition now must be to drive up patients' experience from 'safe' to 'high quality' (Carvel 2008). This perfectly describes the challenges facing acute mental health wards. There has been a significant amount of work with much still to do on the safety of acute wards, yet we must also focus on the provision of high quality care - from a patient's perspective.

2.3 Previous research into Psychiatric Intensive Care Units

Literature review

When undertaking qualitative research there are differing views about whether a literature review should be undertaken before the data generation stage or when considering the findings (Ryan et al 2007), and also the extent of the review required before the commencement of a study (Creswell 2007). Creswell (2007) supports the completion of a literature review before data generation in order to ascertain where the study may be positioned in the larger literature. A literature review at this stage also supports the identification of three key areas (Hek et al 2002):

1. Whether the research question has previously been explored.
2. If the research question and aims are clear, focused and related to the topic.
3. To explore all relevant knowledge and research methods related to the topic.

As identified through the review of the approaches in Chapter three, the selected approach to this project is interpretative phenomenological analysis (IPA). It is identified within IPA that knowledge may be widened through a literature review before data generation and that it supports why the study may make a useful contribution (Smith et al 2009).

Therefore for this project the literature review was undertaken prior to the data generation. Within the discussion in Chapter five and '*as in the nature of IPA*' (Smith et al 2009 p. 113) further new literature is referred to.

This literature review was iterative and a multi-faceted process in keeping with the context of the emergent nature of qualitative research (Walsh and Downe 2005). In line with existing advice (Cronin et al 2008; Holopainen et al 2008; Creswell 2013) the following steps were identified and followed:

1. Identification of key search terms.
2. Search of appropriate databases.
3. Review of selected abstracts.
4. Full review of final selection.

1. In order to identify key search terms I considered the existing literature I was aware of through the work undertaken and discussed in the previous section of this Chapter. This endeavoured to position the project within the on-going literature and be able to provide a clear rationale for the research aims (Creswell 2007).

Also, in light of the history and definition of PICUs, the search terms included 'mental health' initially. This was to ensure that the scope of the search allowed for review of studies that focused on the experience of patients in acute mental health care in general.

In addition an existing literature review undertaken for Psychiatric Intensive Care Units (Bowers et al 2008) was considered to elicit key words and phrases. These were evaluated against the central focus for this project; that of patient experience.

Once the key words were refined I carried out 10 searches using the following terms:

- Mental Health.
- Psychiatric Intensive Care.
- Patient experience.
- Patient Satisfaction.
- PICU.
- Psychiatry.
- Outcomes.

2. In line with identified commonly used databases relevant for nursing research (Timmins and McCabe 2005; Cronin et al 2008) I searched the following databases:

- PsycINFO.
- Medline.
- CINAHL (BNI).
- ASSIA.

The search included articles written in English relating to adult services. This was based on previous work that indicated that relevant qualitative work on the experiences of patients receiving acute inpatient mental health care had been carried out in other countries, for example the Netherlands and Australia.

This was further supported by a literature review that had been carried out in Australia relating to 'Close-observation areas in acute psychiatric units' (O'Brien and Cole 2003).

The initial review of the search identified 548,574 abstracts relating to mental health and 1,900 abstracts relating to psychiatric intensive care. Once more specific terms were added into the searches this number reduced to 843 abstracts.

3. A review of the initial cohort of abstracts was then undertaken. Following this 70 papers were initially selected. Once the duplicate papers were

eliminated, 42 papers remained. The detail of this is outlined in Figures 4 and 5.

These were all further reviewed for inclusion. This was completed by a further review of the abstracts and key subject areas. This review eliminated a further 31 papers leaving 11 papers remaining for inclusion in the literature review at this stage.

These final 11 papers were read in full for inclusion in the review. Those that did not meet the criteria of focusing on patient's experiences and satisfaction of care received were excluded.

4. The final selection of seven articles were further reviewed in full, which identified very little on the quality of care experienced by mental health patients. Additional 'grey literature'¹⁰ was obtained through other sources. This particularly relates to surveys and work conducted by patient organisations, specifically MIND and 'Rethink'. In addition searches of the virtual ward¹¹, the National Association of Psychiatric Intensive Care Units (NAPICU) and National Institute for Mental Health in England (NIMHE) websites.

Once key documents were obtained their reference lists were assessed and a snowballing effect of obtaining literature took place. This approach reflected 'real world' search patterns, where the retrieval of one paper leads to others (Walsh and Downe 2005, p.110) and continued until the same references were discovered over again and a decision was taken that saturation had been achieved.

¹⁰ The term '*grey literature*' is generally used to describe materials not published commercially or indexed by major databases. Types of documents that traditionally have been considered grey are theses, dissertations, conference proceedings, newsletters, meeting minutes, research and evaluation reports and annual reports (Olson 2013). For the purposes of this report this includes those produced by patient groups and national bodies.

¹¹ The virtual ward (<http://www.virtualward.org.uk/>) is a website set up to provide information on an 'ideal acute mental health ward' and contains a variety of documents and papers specifically relating to acute mental health nursing.

Initial search identified 548,574 abstracts relating to mental health

Initial search identified 1,900 abstracts relating to psychiatric intensive care

With addition of specific search terms this reduced to 843 abstracts

Review of abstracts to ensure related to mental health and were qualitative research reduced the number to 70 abstracts

All duplicate papers (28) were removed, leaving 42 abstracts.

Abstracts reviewed against key subject areas identified in initial search themes, patient experience, patient satisfaction, and outcomes of care. Further 31 papers eliminated. 11 papers remained for inclusion.

Final 11 papers reviewed for inclusion in the review. Those that did not meet the criteria of focusing on patient's experiences and satisfaction of care received excluded.

7 papers remained for inclusion in the review.

Figure 5: Flow chart of search process

Literature review findings

Despite a body of evidence that has built up over the last 40 years through a host of studies employing a number of approaches, very little is known about the quality of care that is provided on acute mental health wards today (Quirk and Lelliott 2001). Quirk and Lelliott carried out a review of the literature on what we know about life on acute psychiatric wards in the UK (Quirk and Lelliott 2001). In doing so they identified the main areas of an emergent picture of acute care, these included:

1. Nurse-patient relationships perceived by patients to be an important aspect of psychiatric in-patient care.
2. Nurse-patient contact is limited.
3. Patients appreciate 'humane' qualities in staff (especially nurses).
4. Life on the ward is perceived by patients to be both boring and unsafe; and
5. Ward conditions were criticised.

They also identified what might be usefully discovered in the future and presented a list of questions to pose and answer through further in depth qualitative methods.

The list presented outlines a number of key areas for exploration and attempts to frame it from the patient's perspective; despite this, it is still a prescriptive list of what healthcare providers want to know rather than what patients as consumers wish to say. If the patient experience is to be changed, healthcare providers need to understand where patients locate themselves and understand their world, and incorporate their frame of reference (Volante 2007). How this may be translated into a change in practice is one of the key and on-going challenges facing mental health service leaders and managers; the first step is to understand the perspective of patients receiving care.

The findings outlined by Quirk and Lelliott echo some of those findings highlighted previously by the Sainsbury Centre for Mental Health,

'Rethink'and MIND, in particular wards being boring and unsafe with poor conditions.

An extensive enquiry has been carried out across three acute admission wards in London. Here an ethnographic approach was used to examine the permeability of acute wards and how the concept of an institution has changed over the last forty years (Quirk et al 2006). Whilst PICUs do not have a forty year history, the methodology employed within this work is key in that it describes an approach that affords individuals under enquiry the opportunity to have freedom of expression and allows what is important to patients to be captured and observed.

A separate literature review on PICUs completed in 2008 by Bowers et al identified that the majority of studies regarding PICUs are retrospective, descriptive and dependant on official records (Bowers et al 2008). This demonstrates the absence of an account of experiences within a PICU from a patient's perspective.

Within the review it is identified that only a few studies have used a comparative group, thus strengthening the findings by drawing comparisons to a control group. A survey by Brown and Bass (2004) is identified by Bowers et al (2008) as being the strongest comparative study. Here they drew comparisons between the PICU and local acute in-patient wards; however, the survey was a case controlled retrospective case note analysis (Brown and Bass 2004) and therefore did not identify any data that was derived from patients.

The literature review also identified that only one survey had been carried out to examine patient perception and satisfaction with services. This survey by Wykes and Carroll (1993) assessed, by a self-reporting questionnaire following discharge from hospital, the quality of the service received rather than the patient experience. The questionnaire used was designed specifically for this survey and covered the facilities offered by the ward and provided feedback on this. For example under 'treatment issues' the questionnaire asked patients about key aspects of information

that should be available to them, which on face value sought their opinion and level of satisfaction;but it did not afford patients the opportunity to indicate themselves what a measure of *their* satisfaction would be. Whilst this study achieved a significant key aim, showing that patients who have been cared for in a PICU environment can be accessed to provide detailed views and constructive criticism (Wykes and Carroll 1993), it did not allow patients freedom in reporting what they wished to be known.

Measuring patient satisfaction within a PICU has also been claimed by other authors (Tooke and Brown 1992, Norris and Kennedy 1992). However, when investigated, their claims are with regard to the use of seclusion and with the broad outcome that staff have a greater preference for the use of seclusion to that of patients. Consequently they provide no further information on patients' satisfaction with their care within a PICU.

As has been demonstrated by Wykes and Carroll (1993), it is possible to obtain views and feedback from patients who have received care within a PICU. Equally it has been identified that there is an absence of work looking at the views of patients' experiences being cared for within a PICU, in particular ensuring that what is revealed is from a patient's frame of reference and not what an organisation has prioritised. Therefore, this project will endeavour to fill the gap in knowledge regarding patients' experiences from their own perspective about being cared for within a PICU.

The study undertaken by Ryan and Bowers (2005) regarding coercive manoeuvres within psychiatric intensive care provided valuable insights into care on a PICU. Despite this it did not seek to understand experiences from a patient's perspective. What it did achieve was to demonstrate that the methods of observation within a PICU could elicit key observations and insights that may help understand care. The study itself reported that a key limitation was that the method did not allow the views of the observed participants to be included. This was both the views of the staff and also the patients' responses to the coercive strategies.

A more recent study on patients' perceptions of the time they spent in a seclusion area has been carried out by Iversen et al (2010). This is a key study as it sought to identify patients' perspectives on a particular element of their care. Most significant was that the researchers sought the experiences immediately following discharge from the seclusion area. Whilst their rationale for this was not identified, in terms of this project it is a key issue; that is to seek the experiences of patients as soon as possible to ensure their memories are not diluted. However, within the paper this was also identified as a methodological consideration that, in part, explains the low completion rate of 44%. It was identified that this was due to the scale being administered immediately following discharge and issues regarding 'symptom pressure' were indicated (Iversen et al 2010, p. 8). No reference is made in the paper to issues with regard to the assessment of a person's mental capacity and the potential benefits of the closeness to discharge.

Additionally the study did not allow patients the freedom to express their own experiences; rather it was completed using an eight item scale that patients scored between 0 and 10. In line with previous work identified earlier in this section, the examples of the questions given in the paper were regarding views about what is important to services and not open ended questions about the patients' experiences. The main findings reported were that patients viewed their stay in the seclusion area as positive with three single key items identified as being specifically positive (Iversen et al 2010):

- support from staff.
- respectful treatment.
- feeling safe in the seclusion area.

Thus, it was concluded that their seclusion areas are clinically effective and acceptable to patients (Iversen et al 2010).

Acute psychiatric close-observation areas in Australia are identified as being similar to PICUs (O'Brien and Cole 2004). A review of mental health nursing practice in acute psychiatric close-observation areas carried out by

O'Brien and Cole (2004) identify some important findings and considerations to take into account for this project.

O'Brien and Cole (2004) carried out an action research project that sought views from staff and patients. Significant findings were the multiple problems that exist in the provision of care in close-observation areas [PICU]. These were presented in three main areas (O'Brien and Cole 2004, P. 89):

- design and environment.
- lack of activity and structured time.
- nursing care.

The study was designed entirely by mental health nurses and managers with a critical reference group from professional and community leaders. Thus there was no evidence of patients or carers being involved in the design and completion of the study. Additionally the study specifically focussed on patients who had been discharged *at least* two months and the sample was selected purposively by the clinical judgement of local health professionals (O'Brien and Cole 2004, p. 91).

O'Brien and Cole's (2004) study therefore elicited significant feedback and findings from several key aspects; it differs from this project in that I aim to include patients and carers in the design of the project and also to endeavour to elicit experience from the perspective of patients as soon as they are assessed as being able to consent to do so.

The final paper included within the literature review focussed on mental health patients' experiences of being understood (Shattell et al 2006). This paper used a phenomenological approach to elicit the views of discharged patients on their perceptions of being understood. Participants were recruited through a newspaper advertisement. The methodology employed sought to obtain '*rich descriptions of the lived experience*' (Shattell et al 2006, P. 236) resonate with the aims of this project, which are discussed in Chapter three. The findings identified by Shattell et al (2006) were notable

in terms of the emotional engagement and what patients identified as being understood. These were:

- *'I was important'*.
- *'it really made us connect'*.
- *'they got on my level'*.

The group of patients under scrutiny and process of the research undertaken by Shattell et al (2006) are not immediately relevant to this project. However, the emotional aspects of being understood in the context of mental health care are relevant and therefore this paper is included within the review, and supports this project in seeking similarities with the experiences of patients being cared for in PICU.

2.4 Aims and research question

Being cared for in a PICU can be a difficult, distressing and stressful time for patients, their family and carers and also provides one of the greatest challenges for the clinical staff caring for them. It can easily be considered as a 'major' life experience. Yet there is very little evidence and understanding about what it is like to experience this intensive care, what is important to patients during this phase and how they feel about the time they spend being cared for in such an intensive way.

Previous research alongside a policy agenda that is increasingly focussing on patient and carer feedback has identified some key and important factors. Despite this, none have been completed from the perspective of the patients and allowed them the freedom to tell us their *account* as they wish to be heard. Rather, feedback has been obtained through questionnaires on the questions that we, as service providers, wish to know.

In light of previous work carried out looking at the impact of mental health inpatient care and the absence of attention given to seeking the experiences from the perspective of patients who have received care in a PICU, the aims of this project are:

- To illuminate patients' experiences of psychiatric intensive care.
- To initiate an understanding of what it is like to be cared for in PICU.
- To explore the meaning that patients' ascribe to their experiences of psychiatric intensive care.

Through the aims identified above, this project will seek to examine:

'By their own account, what are patients' experiences of their care during their time spent in a Psychiatric Intensive Care Unit?'

2.5 Summary

Through a description of the history of psychiatric intensive care, its role, function and purpose, this chapter has provided an introduction to my project. Additionally the evolution of the PICU and its journey to become an integral element of acute mental health care has been demonstrated.

The national policy drivers that have charted the journey of acute mental health and PICU care to the current day are outlined identifying the emerging role of patient and carer feedback on services.

Previous research into acute mental health care generally and PICUs in particular has been explored, identifying the lack of a true research profile on intensive care and that the research that has been undertaken is retrospective, descriptive and dependant on official records (Bowers et al 2008). Collectively this provides a clear focus for this project. Based on these findings and my previous experience and knowledge this project is therefore focused on patients' experiences of psychiatric intensive care.

The chapter concludes with a brief statement on the aims of the project and my research question. Chapter three will go on to describe my research methodology in detail and outline the four phases of the research utilised in this project.

Chapter 3 - Methodology

3.1 Overview

Chapter three moves from the background and rationale of the project and focuses on the methodology. Firstly the process for selecting a qualitative approach and specifically the choice of Interpretive Phenomenological Analysis (IPA) is presented. Following this the project design and structure is outlined. The chapter outlines the ethical considerations and approach to quality undertaken within the project. Finally the role and impact of the patients and carer research group is described including the structure of the observation sessions within the PICUs.

3.2 Methodology

Quantitative and qualitative research and the research question

This project focuses on patients' experiences of the care that they receive during time spent in a PICU. Vitally, this should be achieved from their own perspective. As stated, the aims are:

- To illuminate patients' experiences of psychiatric intensive care.
- To initiate an understanding of what it is like to be cared for in a PICU.
- To explore the meaning that patients ascribe to their experiences of psychiatric intensive care.

Quantitative Research

Definitions of quantitative research are numerous and include:

'Quantitative research employs strategies of inquiry such as experiments and surveys, and collects data on predetermined instruments that yield statistical data.'

(Creswell 2003, p. 18).

'Is a formal, objective, systematic process to describe, test relationships, and examine cause and effect interactions among variables.'

(Crookes and Davies 1998, p. 326).

Specifically in the field of nursing research a valuable definition is:

'Quantitative research usually contains numbers, proportions and statistics, and is invaluable for measuring people's attitudes, their emotional and behavioural states and their ways of thinking:

(Shields and Twycross 2003, p. 24).

Quantitative research is also defined as a type of empirical research into a social phenomenon or human problem, testing a theory consisting of variables which are measured with numbers and analysed with statistics (Creswell 1994; Gay and Airasian, 2000). Despite the identification of quantitative research into a human phenomenon, it is the fact that it requires to be measured and analysed through numbers and statistics that discounts this design for this project.

Qualitative research

By contrast qualitative research is seen as difficult to define because of its multifaceted nature underpinned by different paradigms (Hitchcock and Hughes 1995). There are some definitions that provide clarity:

A systematic, interactive, subjective approach used to describe life experiences and give them meaning. '

(Crookes and Davies 1998, p. 326)

Qualitative methods are used when the meaning of something needs to be found, or examining the meaning of an experience, illness, or condition. '

(Shields and Twycross 2003, p. 24).

A qualitative approach affords the opportunity to allow people to speak in their own voice, rather than conforming to categories and terms imposed on them by others (Sofer 1999). This was highlighted as a key concern in the literature review of patient satisfaction and feedback on inpatient mental health services. Historically work has centred around inquiry from the health providers perspective rather than what patients wish to say.

In light of these definitions and set against the aims of the project it was decided that a qualitative approach for this project would be the most suitable course.

Research question in light of the four elements of research

Crotty suggests that the starting point in a research project requires the answer to two questions. First, what methodologies and methods will be employed in the research and secondly, how the choice of methodology and method is justified (2007).

As previously stated the central aim of this project is to elicit patients' understanding of their time being cared for in a PICU. In particular 'What are the experiences of being cared for in PICU?'

Similarities and differences exist within the realms of ontology and epistemology with regard to phenomenology (Lavery 2003). Various perspectives identify similarities including views that demarcating modes of knowledge, beliefs about what *is* [Ontology] and what we can *know* [Epistemology] have essentially the same effect (Stanfill 2012). Equally, that ontological issues and epistemological issues tend to merge together (Crotty 2007, p. 10).

Within qualitative research, reality is subjective to the participants taking part in the study and similarly through the process of undertaking the research the researcher endeavours to lessen the distance between themselves and the participants (Creswell 2007). This is equally true for this project where through the process of the study I wish to understand psychiatric intensive care and the meaning patients ascribe to that experience.

Therefore for the purposes of this project I have adhered to Crotty's concept of the four elements and maintained his stance that ontological issues and epistemological issues can combine (Crotty 2007). Figure 6 outlines the proposed elements of this project.

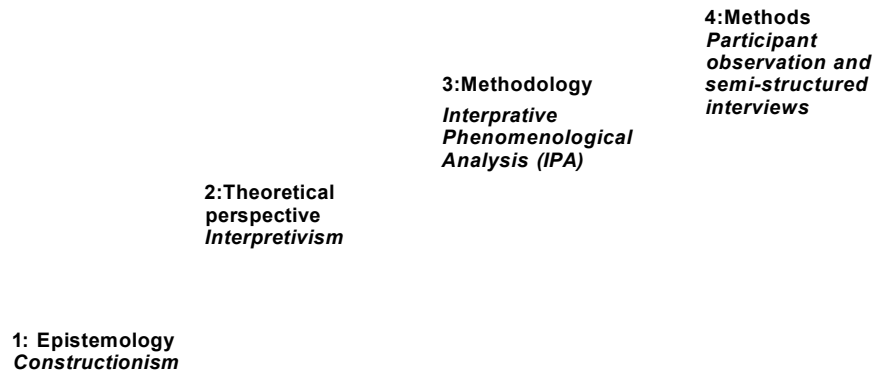


Figure 6: The Four Proposed Elements of the Research Project

Epistemology

Epistemology is concerned with the nature of knowledge (Mason 1996) and with ‘providing a philosophical grounding for deciding what kinds of knowledge are possible and that they are both adequate and legitimate’ (Maynard 1994, p. 10). The epistemological starting point for this project is that of social constructionism. Social constructionism declares that explanations of illness are social, cultural and personal products rather than universal truths (Jones 1994). Different people may construct meaning in different ways, equally different people may have different experiences within the same phenomenon (Crotty 2007) and this may include people’s experiences of mental health and distress and the care they receive. This supports and in turn is supported by debate about mental health and social exclusion, a prevailing view is that mental health is a social construction and that it is difficult to define and deconstruct the relationship between individuals’ social experiences and their mental health (Gale and Grove 2005).

Crotty (2007) asserts that meanings are constructed by human beings as they engage with the world they are interpreting (Crotty 2007), equally people have the ability to tell others what they mean [and interpret] by some behaviour, idea or remark (Brewer 2002). In order to start to understand what it is like being cared for in a PICU, I need to endeavour to understand and interpret experience. One way to do this is to observe and hear the communications of the patients; this may be verbally or through their behaviour, expressions or their interaction with others.

This view is supported by Creswell (2007) who states that the goal of social research is to rely as much as possible on the participants' views of the situation and that they are formed through interaction with others. Crotty (2007) describes this further, stating that constructionism is the view that all knowledge and meaningful reality is constructed through the interaction between human beings and their world, within an essentially social context. For the purpose of this project, a patients 'world' will, given the restrictive nature of the environment, be the PICU.

Everyone's social and life experiences are different, as in constructionism, truth or meaning comes into existence in our engagement with our world (Crotty 2007), consequently 'meaning' is constructed. A persons' social status has a direct impact on their health and vice versa, with those from a deprived background being seen as at greater risk of developing mental health problems (Social Exclusion Unit 2004). Equally it has long been recognised that adults with mental health problems are among the most excluded and disenfranchised groups in society (Gale and Grove 2005).

Theoretical perspective

The relevance of a person's background and social status to this project is that it could indicate the patients approached as part of this project, because they are being cared for in a PICU, will have a higher chance of originating from a socially disenfranchised and deprived group.

This assertion is key when considering the theoretical perspective for this project. In turn the assumptions that collectively constitute the theoretical

perspective adopted for this project require to be examined in order to establish the most appropriate methodology to be employed (Crotty 2007).

Social deprivation and isolation increase the risk of someone developing mental health problems; on the other hand people with mental health problems are more likely to suffer from social deprivation and exclusion (Gale and Grove 2005, p.103). This serves to underline the inter link between a person's social experience and their health. Equally, patients cared for within a PICU may well experience the greatest exclusion and be those least likely to be heard.

Similarly, the very nature of the care that a PICU provides and the necessity to protect the privacy and dignity of those being cared for within, has resulted in many PICUs being located away from the public gaze, paradoxically this also means that the services and care provided and the experiences of those within a PICU are out of sight. Denzin and Lincoln (2005) define qualitative research as consisting of a set of interpretive practices that make the world visible. This further supports a key outcome of this project, to illuminate the experiences of those being cared for within a PICU and as a result make their world visible.

Review of the methodological approaches to qualitative research

This is a study on the provision of healthcare in a particular environment that adopts constructionism as its epistemological framework. The literature review highlighted an absence of perspective from the patient's viewpoint.

Creswell (2007) places emphasis on the '*process of research*' (p.37) indicating that it flows from philosophical assumptions through a theoretical lens onto the procedures involved. Previous work undertaken by Wykes and Carroll (1993) indicates that it is possible to elicit patients' views. However, the absence of a patient's perspective in the literature regarding psychiatric intensive care leads me to conclude that to date patients have not had an opportunity to voice their experiences. Therefore the methodology required needs to seek to understand the experiences from

the patients (participant's) perspective and so, as identified, a qualitative approach is required.

When looking at the different qualitative approaches the overriding link to the theoretical perspective is that the group under enquiry share a common experience of being cared for in the specific environment of a PICU. The focus of the inquiry is the shared experience of intensive care. This principle helps to select the most appropriate methodological approach for the project.

Creswell (2007) identifies five qualitative approaches to inquiry:

- Narrative research.
- Case Study.
- Grounded Theory.
- Ethnography.
- Phenomenology.

Whilst they all differ in what they are trying to accomplish they do all begin with a research problem, proceed to a question, employ similar data generation techniques (in varying degrees) and proceed through the analysis and report (Creswell 2007). Nonetheless, it was important to look to their differences when selecting the most appropriate approach for my project. To assist this, the approaches identified by Creswell (2007) are presented diagrammatically in figure 7.

When returning to the original aims of this project, to understand what it is **like** to be cared for in a PICU and that it is a study of the **accounts** of patients receiving psychiatric intensive care, the two most preferred methodologies were an ethnographic or phenomenological approach. In order to determine this and the ideal methodology, all approaches are required to be considered against the aims.

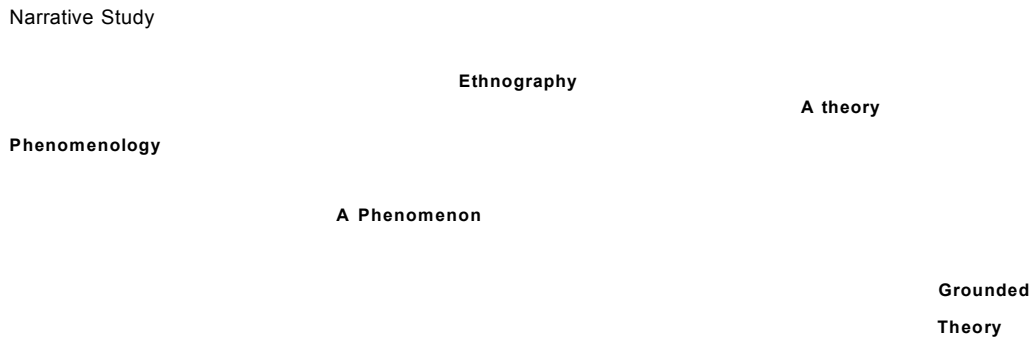


Figure 7: Differentiating Approaches by Foci (Creswell 2007, p. 94)

Narrative research

Narrative research may be identified as an appropriate methodological choice; however, when considering the characteristics of and the differences between narrative research and the aims of this project the reasons that it was excluded become apparent.

Narrative research seeks to understand the meaning of participant's experiences of an event; it relies on the narrative and story being told by the participants and the chronological connection of the story and accounts (Creswell 2007). The project concludes with a narrative about an individual's life. As the participants I was seeking to recruit would be within a profoundly emotional time in their lives, I felt that a more engaging methodology would be required that would support my role as a researcher.

Also and of equal significance, I wished to seek to understand and make sense of their experiences and to be able to describe the essence to those experiences. Equally given the intensity of these experiences, the narrative of their care in a PICU may be difficult to recollect.

Case Study

Case study research explores in depth an event, activity or process of one or more individuals (Creswell 2003). Creswell also identifies through some detailed debate that within case study the investigator explores bounded system (a case) or multiple bounded systems (cases) over time (Creswell 2007). Whilst this approach may initially seem appropriate for patients cared for in a PICU as a 'bounded system' and the principle of focusing on an issue or concern (Creswell 2007). When referring to the aims of this project to understand experiences of patients and the meaning the experience has for them I concluded that case study research would not be the approach of choice to establish the essence of the experience of patients.

Grounded Theory

There are several styles of grounded theory, though broadly, the intent of grounded theory is to move beyond description to '*generate or discover a theory*' (Creswell 2007, p. 63). There are a number of essential data collection methods that should be present for it to be called a grounded theory study (Connelly 2013). These include: open initial coding, concurrent data collection and analysis, writing memos, theoretical sampling, constant comparative analysis, theoretical sensitivity, intermediate coding, core category selection, and theoretical saturation (Birks and Mills, 2011).

Whilst grounded theory may have a role in future studies of PICU, it was not the chosen methodology at this stage since the core aim of this study was to seek the essence of the experience of patients in a PICU and their interpretation of the experiences. The patients journey into and out of PICU would be changeable and may fluctuate greatly. The window of opportunity to carry out an interview with them once discharged from the PICU is anticipated to be small and unpredictable; therefore the structured approach of grounded theory would not lend itself to achieving the study aims.

Ethnography

Strengths of an ethnographic approach include situations where the perspective that a person's culture or the shared cultures of a group may be suspected of affecting the population's response to care or treatment (Hancock 2002). Whilst this may be seen as appropriate for a group of patients within a PICU, it would not get to the core of the aims of this project, to seek to understand the experiences of the group. Ethnography would describe and interpret the cultures of a group but would not provide an insight into the essence of the experiences of the group of patients and the meaning that they attribute to their experiences. Given this potential uncertainty regarding a patient's identification with a culture, ethnography was not appropriate for this study.

Mental health services and interventions are becoming increasingly complex, with an increase in the provision of psychotherapeutic and social support. It is also noted that our understanding of these complex therapeutic processes is largely as a result of comprehensive qualitative research, evaluation and audit and that there is a need to add to this knowledge from a social science perspective (Larsen 2007).

This became a key decision point in terms of methodology. I wished to understand the patient's experiences of the phenomena of being cared for in a PICU. Therefore I favoured a phenomenological approach. Reports and narratives about the content of clinical encounters are predominantly from the clinicians' perspectives only and do not usually account for the experiences of patients. What I wished to do was understand the experiences of patients and also the meaning that they ascribe to that experience.

Phenomenology

There are a number of phenomenological approaches. Whilst they encompass different emphases they do share a common interest in 'what

the experience of being human is *like*' (Smith et al 2009). Smith et al (2009) identify four major phenomenological philosophers; Husserl, Heidegger, Merleau-Ponty and Satre, each developing core phenomenology in their own distinctive way.

A founding principle of phenomenology is that experience should be examined in the way that it occurs (Smith et al 2009) to allow features of the world to be considered according to their manner of appearance (Silverman 1980). Phenomenology is particularly described as a '*philosophical approach to the study of experience*' (Smith et al 2009. P. 11). It is also explained as '*revealing meaning*' (Flood 2010), and the study of a phenomena or '*thing*' (Priest 2004). Husserlian phenomenology describes going '*back to the things themselves*'. The 'thing' being the experiential content of the consciousness (Silverman 1980; Smith et al 2009).

Husserl identified that phenomenological inquiry should examine experience in the way that it occurs on its own terms (Smith et al 2009). This led to a descriptive phenomenological approach to inquiry (Cohen 1987). Here it is argued that the researcher should strip themselves of all prior expert knowledge and biases and also by some authors, that a literature search should not be completed prior to the inquiry commencing (Lopez and Willis, 2004). Equally, within descriptive phenomenology it is identified that the researcher should be continually assessed to ensure all biases and pre-conceptions are eliminated and do not influence the object of study. Specific techniques such as bracketing have been developed (Lowes and Prowse 2001; Racher and Robinson 2002; Lopez and Willis, 2004; Priest 2004; Smith et al 2009). The role and impact of bracketing within this project is discussed later in this chapter.

The work of Husserl was further reinterpreted by Heidegger, Merleau-Ponty and Sartre. It is the work of Heidegger and his development of interpretive phenomenology that is relevant within this project.

Heidegger commenced his career as a student of Husserl (Lopez and Willis, 2004; Smith et al 2009); the influence of Husserl cannot be ignored. Heidegger supported and agreed with the declarations of Husserl, that phenomenology is concerned with human experience (Dowling 2007). In spite of this Heidegger moved away from Husserl's descriptive phenomenological approach (Flood 2010) and advocated the use of hermeneutics as a research method (Lopez and Willis 2004; Dowling 2007; Smith et al 2009; Flood 2010) based on the view that lived experience is an interpretative process (Racher and Robinson 2002) and that the perspective proposed by Husserl would create a distance from human experience rather than an orientation towards it (Silverman 1980).

Interpretative or hermeneutic (Flood 2010) phenomenology developed by Heidegger has a number of concepts that are particularly relevant to this project. Hermeneutics goes beyond description of core concepts and look to what people experience rather than what they consciously know (Solomon 1987; Lopez and Willis 2004; Flood 2010), I feel this is of great importance within this project. The focus of the experience is during a time of emotional distress and it is the patient's experiences that are of significance and interest.

Equally it is identified that while individuals are free to make choices, their freedom is not absolute, it is restricted by the specific conditions of their daily lives (Flood 2010). This is particularly important given the restrictive nature of the PICU and consequently the necessary boundaries and structures that are imposed, not least by the Mental Health Act 1983 (DH 2007a). Heidegger's concept of *intersubjectivity* is also of significance to this project. *Intersubjectivity* is described as the 'shared, overlapping and relational nature of our engagement in the world' (Smith et al 2009, p. 17), as described earlier, for the purposes of this project the patients 'world' will be the PICU.

A further principle that Heidegger considered was that of the relation of the individual to his '*lifeworld*' (Lopez and Willis 2004). Here Heidegger used

the phrase lifeworld to express the idea that a person's realities are invariably influenced by the world in which they live. This, he purported, should be the focus of phenomenological inquiry. Therefore, it is argued that it is not the pure content of human subjectivity that is the focus of a hermeneutic or interpretative inquiry but, rather what the individual's narratives imply about what he or she experiences every day.

The philosophical basis for this project must now be reconsidered to ensure that there is a clear link between it and the phenomenological approach proposed in order to guide the method (Stubblefield and Murray, 2002; Lopez and Willis 2004). The epistemology of this project asserts that truth or meaning comes into existence in our engagement with our world (Crotty 2007) and that meaning therefore is constructed. Phenomenology offers an approach to inquiry that corresponds with nursing philosophy in particular the art of understanding individuals and their meanings, interactions [and engagement] with others and their environment (Lopez and Willis 2004).

I would therefore conclude that the underpinning philosophy of a phenomenological approach is appropriate to respond to the epistemological assumptions that focus this project and outlined earlier in this section. In addition as identified by Spiegelberg (1976), hermeneutics is a process and method for bringing out and making manifest what is normally hidden in human experience and human relations.

Given that the very nature of the PICU results in them being hidden from sight and the assertion that qualitative research consists of interpretive practices that make the world visible (Denzin and Lincoln 2005) an hermeneutic phenomenological approach is judged to be suitable for this project.

Considering the interpretive or hermeneutic work of Heidegger led me to a methodology favoured by psychologists, Interpretive Phenomenological Analysis.

Interpretive Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is 'committed to the examination of how people make sense of their major life experiences' (Smith et al 2009; p. 1) Additionally IPA aims to explore the thinking and experience of participants and therefore through such an approach a greater understanding of care in a PICU in a way that could inform the development of services and enhance the quality of care may be obtained.

IPA as an approach to research has been informed by three key areas, phenomenology (as described in the previous section), hermeneutics and idiography (Smith et al 2009). Originally hermeneutics has been concerned with the interpretation of biblical texts and with an endeavour to uncover the original intentions of the author/s of such documents. In relation to the study of human experience and clinical qualitative research, hermeneutics goes further than description and looks for meanings embedded in everyday life. These meanings are not always apparent to the participants but can be gleaned from the narratives produced by them (Lopez and Willis 2004). Both hermeneutics and idiography are discussed later in this section.

There are two complementary commitments of IPA, firstly, the ***phenomenological*** requirement to understand and 'give voice' to the concerns [experiences] of participants, and secondly, the ***interpretative*** requirement to contextualize and 'make sense' of their reflections (Larkin et al 2006).

IPA is a qualitative approach committed to understanding how individuals make sense of their life experiences. It has its roots in psychology, and recognises 'the central role for the analyst' in making sense of the personal experiences of research participants (Smith 2004). The act of making sense of participant's experiences is one thing that distinguishes IPA from

other phenomenological approaches and also that highlights this as the key choice for this project.

Selecting Interpretative Phenomenological Analysis (IPA)

IPA was selected for two particular reasons.

Firstly the central aim of the project, to understand the 'experiences' of patients by their own account, is consistent with a central aim of IPA, to explore experience on its own terms (Smith et al 2009, p.1). More recently and also significant for this project is the identification that the specific area of research within IPA is illness experience (Smith 2011), whilst the participants illness is not the central experience under scrutiny, it is the experience of care as a consequence of their illness that is the focus. Despite this the participants' experience of illness cannot be divorced from the significance of their experience.

IPA requires the researcher to engage with participants and interpret their experiences. This hermeneutic process is complex in relation to IPA in that the researcher is trying to make sense of the participant trying to make sense of what is happening to them (Smith 2011). This process is referred to as a 'double hermeneutic' (Smith et al 2009, Smith 2011). The concept of a double hermeneutic can be traced back to Giddens who, in 1984 identified that in social theory an external reality that is different to the '*practical consciousness of the lay agents*' [those within a 'world'] and that these discoveries can improve practice (Kyung-Man 2004, p.35).

However, in keeping with Smith et al (2009) and Smith (2011), for this project, double hermeneutics is taken to mean engaging with the participants and their experience of intensive care and to seek to interpret their interpretation of the care they receive.

Secondly, through the idiographic nature of IPA. Idiography is concerned with the particular (Smith et al, 2009 p. 29). This project aims to understand the particular experiences of patients in a particular context at

a particular time in their care. How IPA may be described as being concerned with 'the particular' works at two levels, each are also of relevance to this project.

First of all through the commitment to the particular or individual, whilst maintaining a focus on what is distinct (Reid et al 2005). Each patient's experience of care and a particular care episode is distinct to them. Therefore analysis must be thorough and systematic, and represent in-depth examinations of the lived experience of the person (Smith 2011).

Secondly IPA is committed to understanding how the experience has been understood from the perspective of particular individuals. Thus IPA investigates how people attribute *meaning* to their experiences (Smith et al 1999). In the context of this project this is taken to mean how a patient interprets his or her experience the context of his or her life experiences and the meaning he or she ascribes to it.

The Role of Bracketing

Bracketing or 'phenomenological reduction' (Racher and Robinson 2002) is a fundamental methodological principle where all preconceptions and presuppositions are held in abeyance or suspended in order to understand the reality of others (Stubblefield and Murray 2002). Importantly this should be completed before the researcher makes sense of and orders the experiences into concepts that relate to the researchers previous knowledge and experiences (Gearing 2004).

Husserlian phenomenology devised phenomenological reduction [bracketing] as a technique for the researcher to hold subjective perspectives and theoretical constructs in check and enable the essence of the phenomena to emerge (Racher and Robinson 2002).

The idea that the ability to bracket existing beliefs, values and knowledge has previously and is still being questioned by philosophers and researchers (Lowes and Prowse 2001). Lowes and Prowse (2001)

identified that Merleau-Ponty, one of the philosophers who reinterpreted Husserl's account of phenomenology, believed that complete reduction is not possible. This is due in part to the fact that a researcher's consciousness is engaged in the world and is an on-going process that cannot be transcended (Lowes and Prowse 2001).

Whilst it is identified that Heidegger's views were that beliefs already held should not be reduced or suspended (Ray 1994), it is further acknowledged that the hermeneutic circle may be perceived as a revision, or new version, of that reduction (Richter and Robinson 2002). Heidegger is identified as asserting that nothing can be encountered without reference to a person's background and understanding of their world and that interpretation is based on this background (Lowes and Prowse 2001). This is further described as its 'historicity' (Richter and Robinson 2002). Additionally researchers must become self-consciously 'historiological' (Richter and Robinson 2002).

Within IPA there are evolving views regarding the use of bracketing. Early discussion around IPA as a methodology identified that master themes may be carried forward from one participant to the next or added to with subsequent accounts (Smith et al 1999). More recent discussion however, gives a greater emphasis to approaching each case on its own merit, to do justice to each participant's individuality (Smith et al 2009) and is seen as the evolving nature of IPA (Pringle et al 2011). Equally, difficulties are acknowledged with disregarding prior knowledge (Pringle et al 2011), viewing a researcher who claims to achieve this as confusing and naive (Finlay 2009).

Smith et al (2009) do go on to acknowledge that the researcher will inevitably be influenced by what has already been found, indeed knowledge cannot be 'not known' and bracketing preconceptions is never fully possible (Davidsen 2013). Therefore within this project, whilst acknowledging the complex discussion regarding bracketing, I have adopted a hermeneutic stance. Whilst I cannot 'bracket' my prior knowledge and experiences fully, I have endeavoured to counter these

through appropriate reflexivity discussed in section 3.5 and also through the role of the Trust Service User and Carer Research Group that have acted as a reference group for this project, discussed in section 3.7.

3.3 The Project

Project Design

The design of the overall study has been introduced in section 3.2 and will be discussed throughout the remainder of this chapter and chapter 4 in detail. A conceptualised diagram of the study is presented in Figure 8.

Two approaches to IPA with regard to sample size have been described. Firstly, that of a basic method of IPA which is termed 'idiographic case-study'. This is suitable for up to 10 respondents and is identified as being at the higher end of sample sizes (Smith et al 1999). There is also evidence of the second approach for larger sample sizes using additional procedures for exploring patterns within and between groups. For these studies, focus or comparison groups were used (Reid et al 2005).

Whilst there are no closely defined rules for sample size (Patton 1990), sampling in qualitative research relies on small numbers, sites or individuals (Patton 1990; Miles and Huberman 1994; Creswell 2007) with the aim of studying a phenomenon in depth with extensive detail collected (Patton 1990; Miles and Huberman 1994; Creswell 2007).

When seeking a richness of data about a particular phenomenon, the sample is derived purposefully¹² rather than randomly¹³ (Reid et al 1996;

¹² Purposive sampling is the 'hand-picking' or selecting of individuals who are seen as being able to add to or inform the topic under investigation and provide the most relevant information in relation to the aims of the study (Crookes and Davies 1998; Creswell 2007).

¹³ Random sampling refers to a process whereby every potential subject in the target population has a known and equal probability of being selected for participation. That probability is quantifiable and can be calculated (Panacek and Thompson 2007).

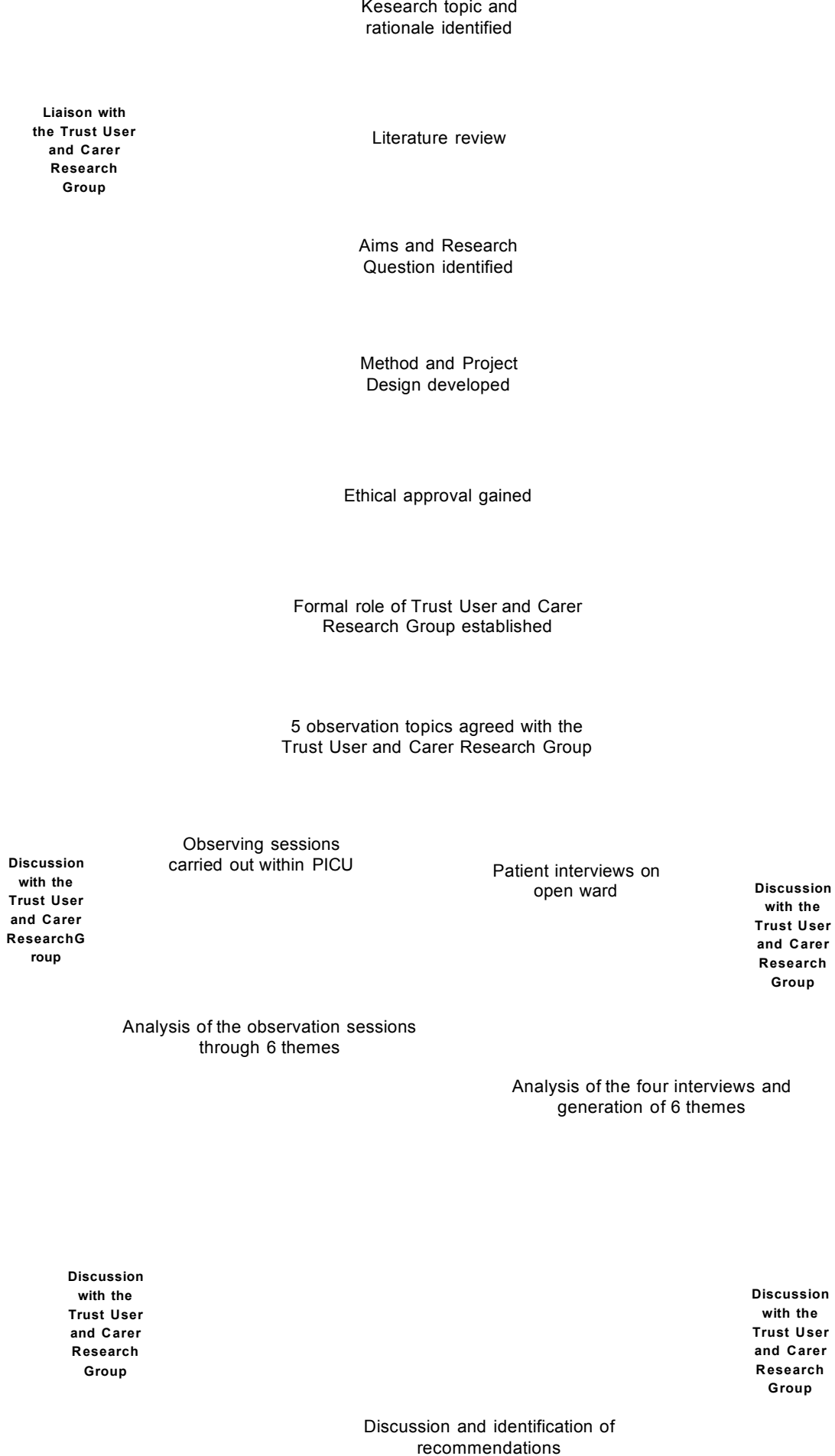


Figure 8: Whole Study Design!

Mays and Pope 1995; Ezzy 2002). This is particularly true of IPA, where the sampling should be selected purposively and be theoretically consistent with the qualitative paradigm in general and with IPA in particular (Smith et al 2009).

IPA, as in other qualitative methodologies, challenges the traditional linear relationship between 'number of participants' and value of research (Reid et al 2005). Smith et al identify that ten participants is considered to be at the higher end of most recommendations for sample sizes (1999). Reid et al (2005) refers to this as 'less is more'.

For this project Reid et al.'s (2005) maxim of 'less is more' was used and the design of this project focussed on the patients within two five bed PICUs. Therefore, as is discussed later, whilst at the planning stage the exact number of participants could not be pre-determined; nevertheless, given the previous admission and discharges rates of the two PICUs, it was unlikely to exceed the recommendations of 10 participants.

Qualitative research data is gathered in a natural setting (Creswell 2007, Denzin and Lincoln 2005), this remains consistent within IPA where the primary source of data collection is in-depth interviews; however, participant observation may also be employed (Smith et al 2009). For this project both interviews and participant observation were the sources of data collection.

Project Structure

The project was structured with four distinct, but due to the methods used, at times overlapping phases.

These are detailed in Figure 9.

The four phases of the project:

Phase 1 - Framing the research.

Phase 2 - Patient observation sessions within PICU.

Phase 3 - Patient interviews on the open wards.

Phase 4 - Notes, data and analysis.

Figure 9: Four Phases of the Project

As previously outlined the aims of this project were to illuminate, explore and understand patients' experiences of care within a PICU. Therefore a key standard within the Department of Health's Research Governance Framework, that *patients, carers or their representative groups should be involved ... in the design, conduct, analysis and reporting of research*' (DH 2005a p. 8.) was maintained by the involvement of the Trust Service User and Carer Research Group. The role of the Trust Service User and Carer Research Group is detailed in section 3.6 and their involvement included in the timeline of the project in Figure 13.

The project was carried out across two adult acute inpatient units within Trust A. Each of the adult inpatient units has two open admission mental health wards (wards O and S, wards B and C) and one five bed PICU (PICU R and PICU D). These are shown in Figure 10.

A typical pathway of care for patients admitted to adult acute inpatient care within the Trust is outlined in Figure 11. This shows that patients are generally, but not always, admitted to an open acute ward. Should the need arise they are transferred to the PICU for a short time and when clinically indicated transferred back to the open admission ward. This remains consistent with an early view of psychiatric intensive care identified by Faulk (1995) in Chapter two, page 9.

Figure 10: Composition of the two adult acute inpatient units*Phase 1 - Framing the research*

The first phase of the research had three main areas. Frame the topics for the observation sessions within the PICUs, continue to work with the Trust Service User and Carer Research Group during the project and also return to the group for validation and checking of the findings.

Phase 2 - Patient sessions within the PICU

Patients whilst being cared for in the PICU are by definition acutely unwell, they may be distressed and present behavioural disturbances. The nature of psychiatric intensive care within the two PICUs meant that all patients were detained under the Mental Health Act 1983 (DH 2007). This in itself did not preclude patients potentially having capacity to consent to take part in the project. However, given the varied diagnoses and reason for admission alongside potential levels of distress and disturbed behaviour, a decision was taken that to approach patients at this stage to establish their level of capacity to take part in the project could be detrimental to their wellbeing.

Admission * 1 of the 2 admission wards PICU

Once clinically indicated

Figure 11: Summary pathway for patients admitted to an open admission ward and transferred to PICU

Therefore for the purpose of the observational work and in accordance with 'Guidance on nominating a consultee for research involving adults who lack capacity to consent' (DH 2008) a consultee for the patients in the PICU was identified.

As previously stated, all patients cared for within the two PICUs were detained under the Mental Health Act 1983 (MHA). A consequence of this detention was that they all had an identified nearest relative as defined under section 26¹⁴ of the MHA 1983 (DH, 1983, 2007). For the purposes of this project, the nearest relative was identified as a suitable person who can act as a consultee and advise the researcher [me] on whether the person who lacks capacity would want to be involved in the project (DH 2008, p.2). In accordance with the guidance the nearest relative was not acting in a professional or paid capacity. A specific information sheet was given to the consultee that contained the same information as a participant information sheet and also additional information relating to their role as the consultee.

¹⁴ Section 26 of the Mental Health Act defines 'relative' and 'nearest relative' for the purposes of the Act. It is important to remember that the nearest relative for the purposes of the Act may not be the same person as the patient's next of kin. (DH 2008a, p. 63 paragraph 8.2).

If the consultee believed their relative would have no objection, they were requested to sign a consultee declaration form and the patient was able to take part in the project.

The observation sessions within the two PICUs aimed to be inclusive of all five patients present at that time. However, they were subject to clinical presentation, approval of the nearest relative, demands of the unit and other operational requirements and were required to be flexible to the needs of individual patients.

The observation sessions were also subject to other dimensions including time, people and context (Hammersley and Atkinson 2009):

- Time – The time and day of the week of the observations considered other activities, routines and engagements occurring for the patients. A selective approach was utilised to attempt to secure better data quality (Schatzman and Strauss 1973) rather than attempt to cover the whole day and week.
- People – The sample included within this project afforded the opportunity to observe all patients. Hammersley and Atkinson (2009) identify that no setting provides a socially homogeneous group in all aspects, the PICU's were in one sense no different and yet they provided a complete group of people receiving PICU care *at that time* if not at any given time.
- Context - The framework identified by Goffman in 1959 was described by Raffel (2013) as where 'backstage' behaviours are depicted as people relaxing and feeling able to drop their front. Indicating that it can be a more trustworthy source of observation (Raffel 2013). A variety of behaviours were exposed within this project. These formed the basis of the observation and enquiry and were not seen as backroom behaviours, the context of the observations was included rather than the PICU simply being seen as a place for the behaviour.

As is discussed in the findings chapters, there were a small number of examples where it was inappropriate to include some services users due to their nearest relative not being contactable, or not themselves having capacity.

In order to provide a framework to my undertaking the observation sessions the four 'types' of observation highlighted by Brewer (2002) were reviewed. These are outlined in Figure 12. They encompass and describe the differing involvement and familiarity of the observer to the world they are observing.

1. Pure participant observation	2. Variation of participant observation
Acquisition of a new role to research in an unfamiliar setting.	Acquisition of a new role to research a familiar setting.
3. Pure observant participation	4. Variation of observant participation
Use of an existing role to research a familiar setting.	Use of an existing role to research an unfamiliar setting.

Figure 12: Four types of observation (Brewer 2002)

As identified previously I have a history of being a clinical nurse and currently have a position of a senior professional nurse within the Trust, therefore the third observation type described by Brewer (2002) was most appropriate for my role as researcher and also for this project.

Patients are transferred from the open acute wards to the PICU and then back again at a time that is individual to them and is led by clinical need. Therefore the timing of the observation sessions in each PICU and the semi-structured interviews were required to be flexible and responsive to both the whole ward communities and also to individual patients. This aspect of following their journey from the PICU to the open ward proved to be a key aspect of the fieldwork, and both required and resulted in detailed relationships with the ward staff and an open communication flow regarding where patients were being cared for.

A key aim of this phase and the observation sessions held was to frame the planned semi-structured interviews and to contextualise the interview

process and outcomes. This was achieved by carrying out the observations sessions before the interviews. The subsequent analysis of the observation sessions was used to support the semi-structured interviews; this relationship is further shown in Figure 8. It was not anticipated that the observation analysis and the master themes generated from the analysis would be used other than to inform the interviews.

However through the analysis and discussion of the findings it was apparent that the master theme of 'atmosphere' identified through the observations sessions was significant to the advancement of intensive care and clinical practice. Therefore this theme was also included in the discussion chapter and subsequently informed the recommendations.

Phase 3 – Patient interviews on the open wards

This project sought to understand individual experiences with participants being required to represent their perspective or experience. Therefore participants for the semi-structured interviews were selected purposively. This is supported by Smith et al (2009) who identify that samples are selected purposively because they can offer a research project insight into a particular experience. Given the low number of patients who had been cared for in the PICU during the observation sessions, all patients who were assessed as having capacity to give informed consent and who did consent to being interviewed were included in this phase. The patient interviews were carried out once the patient had been transferred back to the open acute ward (Figure 11).

Prior to interviews being carried out each patient who had received care in each PICU was approached with a view to taking part in phase 3. Key to this approach was to ensure that patients did not feel under pressure to consent. Their capacity to consent was assessed in conjunction with the clinical care team and I approached those who had capacity to discuss involvement in the project.

All participants were offered the opportunity to check their completed interview transcripts.

Phase 4 – Notes, data and analysis.

Within this project there are two sets of data:

- Observational data.
- Semi-structured interview data.

Observational data:

The observation topics identified with the Trust Service User and Carer Group identified in Figure 15 were used to develop an observation schedule (Appendix 5). Brief notes were taken immediately following each observation period, and more comprehensive notes were written up later the same day. These notes underwent analysis as with the semi-structured interview transcripts. From the analysis 6 master themes were identified. These master themes were used to inform the semi-structured interviews. Additionally one of the master themes, 'atmosphere', was also included within the discussion chapter.

Semi-structured interview data:

Participants were asked to consent to their semi-structured interview being recorded either by audio-recording or by hand written notes. Three participants opted to have their interviews taped and one wished for the notes to be handwritten. The transcripts were then analysed in accordance with IPA methodology, this is detailed later in this section.

The timeline of the project is included in Figure 13. This provides a pictorial perspective on all four phases of the research, particularly with regard to the observation sessions and identifies their overlap with the interviews carried out on each of the open wards.

Time
Phase of Project

Dec-11 Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13 Feb-13 Mar-13 Apr-13 May-13

Participants

Recruitment

The initial process for the recruitment of participants was all patients who were admitted to either of the two PICUs during the observation phase. In order to plan this part of the project I met with the Modern Matrons and Ward Managers for both PICUs and discussed the project. This included the different phases and requirements for each. They were also provided with background information to the project, the consultee information sheet (Appendix 1) and a consultee declaration form (Appendix 2). They were notified when the observation phase for their particular PICU had commenced and at that stage the Ward Manager approached the consultee for each patient already on the PICU, additionally they also approached the consultee for all new admissions during the observation phase. At the same time I also met with and completed the same communication process with the Ward Managers on the four open wards providing them with a patient information sheet (Appendix 3) and consent form (Appendix 4) relevant to the interview phase of the project.

Once the consultee had been approached and the project discussed with them they were given as much time as they wished to make a decision about the relative taking part in the research. Once the consultee declaration had been signed the patient could be included as part of the sample for the observation phase. This was an iterative process and was flexible to meet the needs of admissions, discharges, my observation sessions and the fluctuating nature of acute and intensive mental health wards. The varying responses are included in the findings section.

For phase 3, the patient interviews, I was notified by staff on the PICU that a patient who was part of the sample and whom I had been observing had been transferred to the open ward. From here I liaised with the relevant open ward and once the patient had been assessed as having capacity by the clinical team, either I or a member of the clinical team approached them to discuss this phase of the project and their inclusion. They were afforded the same approach as their relative in that they were provided

with an information sheet, a short discussion was held with them to go through the information and they were then able to take as long as they wished to decide whether to take part in the interview or not.

Inclusion and exclusion criteria

All patients admitted to each PICU were considered for inclusion in the project. Though during the process of seeking the views of the consultee, the views from the clinical team were also taken into account.

No patient was included in the project when there was an opinion from either the consultee or those caring for the patients that, due to the nature of their mental health problems, to be included in the project would be too distressing to them. As is described in the findings section, due to a number of reasons, there were several participants who were not included in the observation phase.

The two PICUs included are part of the acute care pathway for the four admission wards and as such any patient on any ward could, should the clinical need arise, be transferred to one of the PICU beds. As the admission criteria for the Trust and the admission wards is for anyone over the age of 16 years, there was potential for a child to be cared for on a PICU. Given the complex nature of consent for a child to take part in research, a decision was made not to include anyone under the age of 18 years in the research. Equally the experiences of children with mental health issues that require care within a PICU is a specific topic and would benefit from its own project. This maintained a greater level of homogeneity for the remaining sample. However, as all those cared for in both PICUs during the observation phase were over 18 years, it was not necessary to exclude anyone for this reason.

Sampling

As identified in section 3.3.2 where the phases of this project are described, there are two sets of participants, with the second set being derived from the first.

In keeping with IPA the participants were selected purposively, in that they were a group of patients who could grant access to the particular phenomenon under study (Smith et al 2009). Specifically they were being cared for in one of the two PICUs that were the focus of the project.

Whilst there are a defined number of beds on the two PICUs, at the outset of my fieldwork, the number of admissions and discharges that would take place could not be anticipated. Based on typical length of stay it could be predicted that the change of patient would be relatively low. Each PICU has five beds; my observation on each PICU was over the course of four weeks. Therefore it was entirely possible that there would be no change of patient during that time.

In fact due to a number of reasons around the clinical care of patients previously discussed, the number whom I obtained the consultee approval for was three in each PICU. The whole figure of six became my potential sample size for phase 3 of my research. Of those six I was able to approach, seek consent from and interview four participants.

Observation topics

From a review of the literature and previous work undertaken in respect of acute mental health wards and PICUs a suggested list of observation topics were formulated, this was discussed with the Trust Service User and Carer Research Group and following their review and consideration an agreed schedule compiled (Appendix 5). As previously indicated the detail of this is discussed later in this chapter. This schedule was used to frame the observation phase and a sheet was completed following each observation session. These were in turn subject to analysis as described and discussed in Chapter four. The data generated through the observations and its subsequent analysis was used to inform the semi-structured interviews.

Interviews

A semi-structured interview schedule (Appendix 6) was developed from available qualitative literature (for example; Bowling, 2005; Bell 2010). This

was then discussed with a placement supervisor and the Trust Service User and Carer Research Group. Four interviews were carried out. Participants were able to select where they wished the interview to take place. This was either in one of the ward's interview rooms, their bedroom or dependant on leave provision, a facility away from the ward. Two took place in a ward interview room, one in the patient's bedroom and one outside in a private garden of the ward.

The interviews lasted between 35 and 65 minutes, three were audio recorded and later transcribed verbatim, with all identifying information removed. One was hand written during the interview. All four interviews were transcribed or copy typed by a Trust administrative officer, bound by NHS rules of patient confidentiality.

Data analysis

The data obtained through the observation sessions and also the interviews with the participants was analysed using the IPA approach. Whilst an iterative and inductive cycle was employed (Smith et al 2009) common processes and principles that have been previously identified in the literature were used:

Processes:

- Moving from the particular to the shared.
- Moving from the descriptive to the interpretative.

Principles:

- Commitment to an understanding of the participant's point of view.
- Psychological focus on personal meaning-making in particular contexts.

(Reid et al 2005)

Within IPA analysis consists of the identification of emergent themes from the transcript, this supports the establishment of both 'master themes' and

the 'superordinate themes'. For the purposes of this project the use of the terms 'master' and 'superordinate themes' will be reserved for the process of the analysis.

The interview transcripts were subject to the stages highlighted by Smith et al (2009):

1. Read and re-read the transcripts.
2. Initial noting.
3. Develop emergent master theme.
4. Search for connections across the master themes.
5. Moving to the next case and repeat.
6. Look for patterns across cases.

Read and re-read the transcripts

The observation notes and interview transcripts were read and re-read. At this stage, only initial notes and considerations were made and used as an opportunity to immerse myself in the original data (Smith et al 2009) and to reconnect with the interview taking place.

Initial noting

The next stage involved an initial level of analysis. The observation notes and transcripts were read and attempts made to engage with the transcript (Smith et al 2009), I made notes in one margin and endeavoured to make sure that these were descriptive and remained close to the participants meaning (Smith et al 2009).

Develop emergent master themes

As I engaged with the transcripts through the *initial noting* stage, master themes became apparent. This process reduced the volume of detail of the transcripts into the notes relating to the master themes. The master themes emerged as statements, words and on occasion, phrases. This enabled me to focus on specific master themes.

Search for connections across the master themes

Through reading and re-reading the transcripts and from the notes I made, additional master themes became apparent. I was able to develop connections across the master themes, this was a powerful stage of the analysis as I read and re-read the transcript. A number of ways to look for patterns across emergent master themes were utilised as identified by Smith et al (2009). This supported the development of super-ordinate themes. Specifically these were:

- Abstraction - identifying patterns between emergent master themes and developing what may be identified as a 'super-ordinate theme'.
- Subsumption - where an emergent master theme may in itself become a super-ordinate theme, this was particularly useful when considering this aspect of the analysis for the transcripts in this project.
- Contextualization - identifying the contextual or narrative elements within an analysis.
- Numeration - the frequency with which a master theme is identified.

Moving to the next case and repeat

Once the master themes and super-ordinate themes had been identified for one case the process outlined above was then repeated for the next case and so on.

During this stage Smith et al (2009) identify that as far as possible bracketing should take place in order to maintain IPA idiographic commitment. Recognising that the researcher will inevitably be influenced by what they have already found, the above strategies will assist in allowing new master themes to emerge with each new case (Smith et al 2009).

Look for patterns across cases

The final step at this stage involves the identification of patterns across cases or, utilising the strategies outlined, the identification of master themes that are different, or become super-ordinate themes in their own right.

3.4 Ethical considerations

Ethical consideration for those with mental health problems being involved in research can be particularly complex. Mental illness may cause people to experience a host of differing symptoms and changes to their thoughts, feelings, relationships and social functioning.

It would be a great ethical mistake to presume that people with mental health problems are therefore incapable of making their own decisions about participating in research (American Psychiatric Association's Task Force on Research Ethics 2006). In addition those with mental health issues have expressed their willingness to be involved in research and to make their voices heard (Koivisto et al 2001).

Rather, in keeping with a principle concern of ethics committees regarding the safety of both the participants and the researcher (Holland 2007), appropriate measures and processes require to be adhered to correctly and sensitively to the needs of those with mental health problems (American Psychiatric Association's Task Force on Research Ethics 2006).

This is particularly highlighted within phenomenology where more subtle approaches have shown that those with mental health issues can be competent to make decisions (Koivisto et al 2001).

In spite of this all research participants must be given particular consideration with regard to their ability to give informed consent. The details of the deliberations for this project are outlined within the remainder of this section.

Informed Consent and Capacity

Legal Framework

As previously described the PICUs are generally locked environments (Bowers et al 2008). The two PICUs included within this project are locked wards and all patients who were observed under phase 2 were detained under the Mental Health Act 1983 (DH 2007a). This did not preclude them from taking part in the project because as outlined, the Mental Capacity Act 2005 and the '*Guidance on nominating a consultee for research involving adults who lack capacity to consent*' (DH 2008a) was adhered to.

For phase 3 of this project the Mental Capacity Act 2005 (DH 2005a) was particularly linked to patients consenting to take part in the project. Within the Mental Capacity Act 2005 there are five overarching key principles. Two of the principles were significant for this project:

Principle 1, the assumption of capacity, and

Principle 3, not to treat the patient as unable to make a decision because the one they make is seen as unwise.

Therefore in accordance with sentiments previously described where people with mental health issues, who do have capacity, should not be excluded from taking part in research; they were approached once their capacity had been established.

Consent

The Mental Capacity Act 2005 provides a framework for the protection of people who lack capacity to make a decision for themselves (DH 2008). Also included within the Act are safeguards for conducting research involving those who may not be able to consent. This may be due to a number of issues including mental health problems. Therefore whilst formal consent was not sought from patients for phase 2 of the project, a consultee was identified for each patient. As all the patients were detained under the Mental Health Act 1983 and as part of this detention all patients had a nearest relative identified under section 26 of the MHA (1983), the

nearest relatives were used as the consultee to provide the declaration regarding the patients taking part in the study. The consultee (nearest relative) was asked if they believed their relative may object to taking part in the study, if the consultee believed they would not object they were asked to sign a declaration form to that effect.

In addition discussions were held with the multi-professional team caring for the patient before the consultee (nearest relative) was approached.

For phase 3, all patients were approached only after their capacity to be able to consent, should they wish to take part, was established. This was done through discussion with the ward clinical team and a review of the clinical records and documented assessment of capacity, anyone who was assessed as not having capacity was not approached to take part in phase three. This accounted for one patient.

The process for obtaining consent for the remaining four patients who were assessed as having capacity to be interviewed was to provide them with an information leaflet, and go through the leaflet responding to any questions they had. All patients were given time, at least 24 hours, to consider their taking part in the project and if they agreed they were asked to sign the consent form, all participants were given a copy of their signed consent form to keep along with the information sheet.

Confidentiality and anonymity

Ensuring confidentiality is a key component within the delivery of healthcare, guided nationally by the NHS Confidentiality Code of Practice (DH 2003) and under the Nursing and Midwifery Council Code of Professional Conduct (NMC 2008).

Alongside adherence to these guiding policies for the purpose of this project the following processes were also adhered to:

- The patients were informed in the information leaflet that all information would be kept confidential; this was also reinforced through discussions with them.

- They were aware that the transcripts and notes would be typed up by a person who was also bound by confidentiality and that all tapes and documents would be maintained securely and separate to any other documentation.
- They were also informed through the consent process that all names and identifying information would be removed and that pseudonyms would be used. However, they were aware that quotes and statements from the transcripts may be used and that they would be non-identifiable.

Potential distress and safety

There was a risk that the process of this project could be distressing to the participants, therefore to reduce the risk of this occurring I employed specific behaviours for each phase in which they were involved.

For phase 2, the observation sessions on each PICU I utilised my skills as a clinical nurse and ensured I was as unobtrusive as possible. I dressed in keeping with the clinical team and in accordance with the Trust Policy, using the same name badge and key and alarm system as the unit team. Essentially I was endeavouring to make myself as inconspicuous and as similar to a member of ward staff as possible.

For phase 3, the interviews, the interviews were face to face and for the participant, an explicit component of the research. Here I was aware that taking part could be distressing to the participant. Therefore in order to reduce any inconvenience and potential distress to the patients I provided them with as much information as they wished and ensured any questions they had were answered prior to the interview being carried out. I planned the interview to take place at a time and venue convenient to them and I ensured they were aware they could take a break and end the interview at any time. They were aware of my clinical background and as would be expected as a nurse working in the field I responded to any questions they had about my knowledge, experience etc.

After the interview I spent a few minutes with each participant engaging in general discussion to ensure they were not at that time distressed by the interview. I also made sure that all participants knew they could approach the ward staff at any time to discuss anything regarding the project, particularly if they had any concerns regarding taking part. Additionally I spent time with the ward team on each occasion prior to leaving the ward to update them on any significant events during my visit.

My physical safety whilst undertaking the work was important. Key elements I used to maintain my safety were:

- I received an induction to the clinical area including information regarding safe practice, lone working, chaperoning and the use of safety alarm systems.
- I provided information to staff working within the immediate environment regarding the project, nature and purpose of the research, time scales and my role on the ward.
- Immediately prior to any period of engagement with any participant I received an up to date assessment of their mental health and risk assessment.

Governance Arrangements and Ethical Approval

Governance

The Research Governance framework issued by the Department of Health in 2005 highlights a number of aims; to bring together general principles of good practice, promote improvements in research quality and to forestall poor performance, adverse incidents and fraud (DH 2005b). This was a single organisation project with one principal researcher, requiring one Research Governance committee approval.

The involvement of the Trust Service User and Carer Research Group detailed in section 3.6 supports a key indicator in the Department of Health's Research Governance Framework, that '*patients, carers or their representative groups should be involved ... in the design, conduct, analysis and reporting of research*' (DH 2005b p. 8.)

Ethical approval

Given that this project involved services users it was required to be reviewed independently via an ethics committee to ensure it meets ethical standards (DH 2005b). This included four steps that were successfully completed prior to ethical approval being sought.

1. The completion of a focused project proposal for submission to the University for Ethics Approval and scientific review.
2. The completion of appropriate documentation (DPS1) for submission to the Research Degrees Sub-committee to apply for full registration as a Doctorate.
3. Appropriate liaison with the Trust Research Governance procedures.
4. Once these three steps had been successfully achieved ethical approval via a flagged National Research Ethics Committee (NREC) was applied for and received, the letter of approval is included at Appendix 7.

Due to changes in circumstances from the original date of gaining ethical approval and commencing the fieldwork for this study a notice of substantial amendment was submitted to the same NREC. The changes in circumstance were:

1. A change in my clinical role.
2. The geographical move of one of the acute units and PICU.
3. A change to my supervisory team.

The NREC letter of approval of these amendments is included at Appendix 8.

Following these amendments further ethics approval was required in order to approach participants to establish their consent for anonymous quotes to be used within this final project report. The NREC letter of approval of the additional consent is included at appendix 9. The additional information sheet is included at appendix 10 and the consent form at Appendix 11.

Once approval was received from the NREC the clinical teams of the four participants were approached to facilitate the additional consent. This has been completed for two of the participants. The remaining two have been assessed by their clinical team as not currently having capacity to make a decision regarding this. This element is on-going and will be completed at a time suitable to the participants. In the event that either of them does not consent to their anonymous quotes being used this report will then be redacted accordingly.

Access to Psychiatric Intensive Care

Access to the PICUs and open adult acute inpatient wards formed part of my day to day work; nevertheless, the project proposal was presented, discussed and agreement obtained to proceed, in a number of forums within the Trust. This included:

- The Adult Mental Health Business Division Governance group.
- The Consultant Psychiatrists group.
- The Trust Research Panel.

As a result of working within the organisation it could have been easy to assume access would be a smooth process. Hammersley and Atkinson (2009) describe a process fraught with difficulties, the most acute being at the beginning; yet, they will persist throughout. In order to ensure I kept the issues with access to a minimum, I made sure that the gatekeepers of the service, the Modern Matrons and Ward Managers and their staff were afforded appropriate regard and recognition for the responsibility and function of their roles and I employed a careful process of negotiation and respect throughout the project.

3.5 Quality

In order to assess the quality of qualitative research a different approach and criteria are required to that of quantitative research. Smith et al (2009) favour two approaches for assessing the quality of qualitative research and refer to the work of Elliott et al (1999) and Yardley (2000).

Following recommendation from Smith et al (2009) and the fact that the work of Elliott et al (1999) relates more specifically to writing for publication, I used the four principles proposed by Yardley (2000) and detailed in Figure 14 to present the quality issues for this project: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. These four qualities require skill to carry out high quality research and through the discussion below I have described how they were used to ensure this project maintained high levels of quality.

Sensitivity to context

Theoretical; relevant literature; empirical data; sociocultural setting; participants' perspectives; ethical issues.

Commitment and rigour

In-depth engagement with topic; methodological competence skill; thorough data collection; depth/breadth of analysis.

Transparency and coherence

Clarity and power of description/argument; transparent methods and at a presentation; fit between theory and method, reflexivity.

Impact and importance

Theoretical (enriching understanding); socio-cultural; practical (for community, policy makers, health workers).

(Yardley 2000, P. 219)

Figure 14: Characteristics of good (qualitative) research.

Sensitivity to context

Demonstrating sensitivity to context starts early on in the research process (Smith et al 2009) and may be fulfilled through awareness of the existing literature, the socio-cultural setting of the study (Yardley 2000) and sensitivity to the material obtained from the participants (Smith et al 2009). I have attempted to demonstrate this throughout the planning process of the project, appropriate communication and awareness of the process and commitment to the sensitive collection of the data. In particular I paid

specific attention to my role during the observation phase of the project and was as discreet as possible, and in my communication to the participants through the recruitment to the interview phase.

Commitment and rigour

Yardley (2000) identifies that commitment can be demonstrated through prolonged engagement with the topic and the development of competence in the methods used. Whilst Smith et al (2009) consider attentiveness to the participants during data collection and the care with which the analysis is carried out as the key ways to demonstrate commitment. I have attempted to fulfil this through my previous clinical background and work within acute mental health care. I have also demonstrated through the method chapter and observation and interview findings in Chapterfour that I have considered the participants through the stages of the project and their episode of illness. I have not previously worked with IPA, but I do have a professional background in interviewing and listening skills and was able to utilise these during the data collection. Equally through the process of analysis I attempted to reconnect with my experiences of being with the participants and I took care to reflect their experiences in a respectful and sensitive way.

Transparency and coherence

Achievement of transparency and coherence can be reached through clear descriptions of the research stages (Smith et al 2009) including the analysis and coding of the data (Yardley 2000). This includes a coherent argument with the master themes logically hanging together (Smith et al 2009) and the construction of a version of reality rather than a description (Yardley 2000). Thus one would see a fit between the research completed and the underlying theoretical assumptions of the approach being implemented (Yardley 2000, Smith et al 2009). I have aimed to deliver a transparent and coherent project through detailed description of the research process, the role of the Trust Service User and Carer Research Groupdescribed throughout this account and through the analysis in Chapterfour. Here I have sought to ensure the reader can identify the

master themes and patterns of analysis from my use of excerpts from the narratives provided by the participants.

Finally through reflexivity I have attempted to ensure my personal role, beliefs, assumptions and actions have been taken into account to understand the impact 'I' have had on the research process and findings.

Impact and importance

The final principle is that of impact and importance. It is not only sufficient to complete a sensitive and plausible analysis (Yardley 2000), it is also necessary to ask if the research is interesting, important and useful (Smith et al 2009). However, Yardley (2000) also makes the point that there are many varieties of usefulness (2000). For this project a key aim was to extend current knowledge around the experiences of people being cared for in a PICU and to enable staff to frame care delivery to support the patient's 'frame of reference' of their experiences. This aspect is considered in the discussion section in Chapter four.

Peer review or debriefing

My 'devil's advocate' (Lincoln and Guba 1985) has taken the form of the Trust Service User and Carer Research Group. As outlined in the methods section, this group has formed a key component within the research in terms of generating initial topics and also to review the data gathered and the analysis being undertaken.

The group agreed a brief that included the role of asking 'hard questions' and challenging my role, findings and the analysis derived from that. They also offered their insights to support the data gathering, analysis and interpretations and provided a greater and richer depth to my work.

Reflexivity

It is identified that social constructionism asserts that explanations of illness are social, cultural and personal products rather than universal truths (Jones 1994). I feel that everyone is individual, made up of their own life

experiences, each as valuable as the other. In keeping with the views of an American Psychologist, Kenneth JGergen, it is our life experiences that construct the people we become (Misra and Prakash 2012). In particular Gergen inspired a large body of research that amongst other benefits, allows the implications of this for clinical practice to be acknowledged (Misra and Prakash 2012).

Social researchers are a part of the social world they study (Hammersley and Atkinson 2009) and are influenced by the experiences and relationships they encounter (Boyle 1994). In order to understand and recognise the role and impact of this during this project I considered two forms of reflexivity suggested by Brewer (2002):

- Descriptive reflexivity.
- Analytical reflexivity.

Descriptive reflexivity

This includes a description of the social location of the research, power relation and the interaction between me and the participants [patients] (Brewer 2002), and how our own values, experiences, beliefs, wider aims in life and social identities have shaped the research (Willig 2001). The PICUs where I carried out my fieldwork are part of my clinical history and form a component of the inpatient environment in the Trust where I still work. I have a role across the Trust in a senior nurse position. The view that all data involves presuppositions (Hanson 1958) is very relevant, my history as a mental health nurse and the many years I have spent working on adult acute inpatient wards forms part of my socio-history (Hammersley and Atkinson 2009), I acknowledge this and have endeavoured to account for it throughout this project.

Analytical reflexivity

Analytical reflexivity takes descriptive reflexivity one step further and seeks to explicate the processes by which understanding and interpretation was reached (Brewer 2002) and the impact any preconceptions may have had

on the data. An intended outcome of the time I spent with the Trust service user carer research group was that they were able to challenge assumptions and conclusions I made through this project. My personal reflexive diary has been an on-going, self-critique and self-appraisal of my moral, social and political stance (Kock and Harrington 1998). This has not only left a 'super' audit trail (Rolfe 2006) but also served to allow for on-going reflection on the process, quality and direction of the project.

3.6 Identifying and seeking consultee approval

Prior to commencing the observations on the two PICUs I spent some time with each of the units Ward Managers discussing the project, aims and anticipated outcomes. Their 'sign up' to the project was secured and they welcomed me onto their unit. Whilst this was not essential in terms of the governance and approvals that were required, I felt the human engagement with the staff who would be involved even in a small way was crucial. Along with the ward team I reviewed each patient for inclusion in the sessions the circumstances of each patient and their nearest relative was discussed and a decision taken how best to approach them for their approval and views.

Each relative was approached in a way that best suited them; a mixture of approaches was used and included either a telephone call to discuss the project or a face to face discussion at their next visit.

A number of relatives were not approached for key reasons that included:

- The patient was expressing paranoia regarding their relative and it was felt that to approach the nearest relative may compromise their relationship further.
- The nearest relative could not be contacted.
- Two patients were not included as they would not be returning to the open wards as they were awaiting a bed in a different, more secure facility.

One further relative appeared to be unwell and did not meet the criteria within the guidance on nominating a consultee (DH 2008) in that they were

not believed to have sufficient capacity to provide an informed view on the patient.

Whilst the approach to the consultee was not about gaining consent as such or to ascertain informed consent, good practice strategies to facilitate informed consent were used to ensure that the principle of beneficence was upheld (Keogh and Daly 2009).

Each relative who was approached was provided with a consultee information sheet (Appendix 1). They were given time to read through the sheet and ask any questions they may have. They were given the opportunity to go home and consider the project and what views their relative, the patient, may have. Both within the information sheet and also verbally they were informed that should they, once they have given a positive response, change their minds their relative may be withdrawn from the project with no adverse consequences.

In total seven relatives were approached to seek their approval. Six gave their approval and did not withdraw it during the course of the project. The final one when approached expressed concerns regarding their relative which indicated that they them self was also unwell and this prompted an assessment of their mental health and no further contact regarding the project.

3.7 The Trust Service User and Carer Research Group

For a number of years there has been an increasing focus on the importance of the patient's experience and the need to focus on improving this experience where possible. In particular, Lord Darzi's report High Quality Care For All (2008) highlighted the importance of the entire patient experience within the NHS.

What remains absent is a clear direction on the involvement of patients in health care research, whilst it can be seen as a logical extension of practice in health (Lopez et al 2010) it is not a universal expectation.

Despite this and in order to achieve a key aim of this project, that of ensuring that the research is carried out from the patient's 'frame of reference' and does not seek to ask what organisations wish to ask of patients, I opted to utilise a patient and carer reference group to support the project.

The existing Trust Service User and Carer Research Group were approached and the members agreed to take the role of a reference group for the duration of the project. Formed in 2007, the group is accountable to the Trust Research Panel and the Trust User and Carer Partnership Council.

The group is made up of patients and carers, who come together to use research to improve services grounded in user and carer experience. The group has registered with the Yorkshire and Humber Research Design Service as an expert reference group, in order that they may be able to offer advice and support to any researchers in the field of mental health. The mission statement of the group is:

'The group will seek to convey and represent the interests of patients and carers in all matters relating to the development, implementation and evaluation of Trust Research and Development policy and practice. It will seek to develop an inclusive research agenda and strategy that serves the interests of patients and carers.'

They have a track record in carrying out research within the Trust and I have worked with them on other projects, therefore they felt a natural group to approach to support my project as a formal reference group throughout my research phase of the project.

A reference group is:

'the group to which services and providers ... must refer if they are to identify accurately what the group's needs are and what are the best solutions ... the group who must finally ... decide ... whether the services ... 'got it right' and their needs are met'.

(Wadsworth 1991, cited in Lammers and Happell, 2004, p. 263).

Equally it is a concept referring to a group to which an individual or another group is compared. They are used in order to evaluate and determine the nature of a given individual or other group's characteristics [<http://en.wikipedia.org/wiki/>]. It is the group to which the individual relates or aspires to relate themselves to psychologically and becomes the individual's frame of reference and source for ordering his or her experiences, perceptions, cognition, and ideas.

In line with previous work regarding the use of reference groups, the role of the group within this project was not to represent all [patients] ... rather to contribute to the research from their own experience (Lopez et al 2010).

For the purposes of this project, however, I have used this term to represent a group of patients and carers who are able to provide me and the project with an expert view on the focus of the research, '*patients experiences of their care during time spent in a PICU*' and for me to be able to check and order my experiences, perceptions and ideas.

In particular I wanted the group to provide challenge to both myself and the project and check its robustness in terms of charting the patient experience.

Given that the aim was to obtain 'real time' experiences the reference group could not be a direct part of the field work. Their experiences as having accessed services or cared for someone who has in the past accessed services meant that they had recognised knowledge, alongside their existing skills as researchers, through their unique experience as patients and carers.

The decision to include the patient and carer reference group helped to address the issues of bias and objectivity, particularly when considering the quality of the project through transparency and coherence described in the previous chapter and also to increase the accountability of both myself as a researcher and also the outcomes of this project to ensure it has 'valued outcomes' (White 2002).

I made contact with the patient and carer research group through the Trust Research Panel and they agreed to meet and discuss the parameters of the project. These early meetings took place from the commencement of my study in 2008 and were slowly framed throughout the course of the project. Initially the meetings took the role of a free flowing discussion around their work to date, my aspirations for the project and their experiences. This was an important time to secure a trusting relationship that enabled the group to develop a clear understanding of the project.

The parameters to their involvement, role and remuneration was discussed and agreed prior to their involvement. It was agreed that as they were part of an established group within the Trust, their work on this project would be encompassed under their existing work.

Work with the Trust Service User and Carer Research Group commenced specifically for this project once ethical approval had been gained.

Over the course of the project five meetings were held with the group. Each took place at a time convenient to the group and at an agreed location. I arrived with an outline of what I would wish to achieve. Each time we met there was always a divergence from this and it always brought new perspectives, challenges and insights that I did not expect to have.

The first formal meeting for the project with the Trust Service User and Carer Research Group took place in May 2012. This was a key meeting as it gave us all the opportunity to set the parameters for the whole project and agree boundaries and timescales.

The outline agenda for the meeting was:

- Agree meetings for the course of the project.
- Hospitality.
- My requirements as researcher - 'critical friend', check and challenge.
- Discuss and agree topics for observations on PICUs.

In preparation for the meeting the available literature around adult acute mental health inpatients wards and PICU had been reviewed, I distilled key recurring topics and issues of note in an attempt to establish what I may observe during phase two of the research.

Detailed in Figure 15, the topics suggested from the literature review detailed in chapter two and the additional topics from my own experience, I believed patients valued were presented to the group.

The Trust Service User and Carer Research Group were able to bring these topics to life and discuss real experiences, one carer particularly described her [relatives] behaviour and the impact positive interaction with staff had on him. She described this as one of the most significant elements of his care and that when he moved ward or unit she could recognise in him the process of getting to know a new set of staff or when his relationship with staff was not as positive. Equally the impact of other patients changing had an influence on his experiences.

Earlier experiences of the use of reference groups describe the involvement of users of services as requiring shared decision making and power to influence the process (Lopez et al 2010) and that patients or clients are recognised as having power through their unique experience as patients (Ife 1997). This was demonstrated through a process of discussion, debate and challenge on what I had extracted from the literature against real life experiences.

The dialogue to refine the literature into topics for this project was focussed around four areas:

1. Gender.
2. Relationships.
3. Changing ward population.
4. Role of staff.

Topics suggested by the literature:

- Boredom/lack of activities.
- Role of the environment.
- Interactions with patients including conversations and relationships.
- Housekeeping - meals, routines.
- Distress - being cared for in a PICU, responses to symptoms.
- Relationships with others - staff, visitors/families.
- What Patients value:
- Support.
- Talking and being listened to.
- Being away from home pressures.
- Safety/sanctuary.
- Freedom/choice.
- Sense of community.

Figure 15: Initial topics identified from the literature review in Chapter two for the observation sessions

Gender

Key topics of mixed sex wards and the impact of different genders were debated, how men and women interact with each other was seen as significant. For the purpose of this project how men and women were seen to mix and socialise within the intensive environment of a PICU was important. The Trust Service User and Carer Research Group identified their experiences of this and the impact in terms of experience, both positive and negative.

Relationships

Relationships were very important to the Trust Service User and Carer Research Group. Particularly interactions between patients, how they

differed from person to person and how patients looked after and supported each other during their inpatient stay. Similarly the way patients witnessed other patients being treated by staff would, the Trust Service User and Carer Research Group said, have an impact on their experience.

Equally significant was the reason why a person is being cared for in PICU and the impact this has on them and their experiences, for example where drug use may be present and the impact on their relationships and recognition of the necessary boundaries of PICU.

Changing population

The Trust Service User and Carer Research Group highlighted the changing population of the PICU and the role of patients being admitted and discharged and how patients feel about this. From their experiences they identified two ends to the spectrum, from feeling left behind and as though they were not improving and progressing, to relief at not having to face the outside world and feeling safe within the ward. Equally important for the group was the impact of having to get to know new people on a regular basis and the impact of an ever changing group of people, this mixed with potential anxiety at being on the ward could, they felt, be significant.

Role of staff

Finally the group felt that interaction with staff was greatly significant in terms of a person's experience. Relationships, how they were formed and the levels of respect afforded to patients were noteworthy.

The meeting concluded with the agreement of a definite list of key topics for the observation sessions. These are listed in Figure 16 with the final format included at Appendix 5.

This initial meeting and the debate that had taken place had very quickly and efficiently taken the clean lines of the topics I had derived from the literature and successfully got to the heart of this project, to establish patient's experiences from their frame of reference.

Final topics agreed with the Trust Service User and Carer Research Group:

- Gender impact.
- Interaction between patients.
- Rapid changing patient group - Dynamics.
- Impact of admissions and discharges.
- Relationships with staff.
- Other significant observations.

Figure 16: Final, agreed topics for observation sessions

Whilst there were some similar topics and connections to the literature, what the Trust Service User and Carer Research Group had done in their role as the reference group, was to provide a clear 'expert by experience' perspective and grounded my proposed observations in a way that could not be done from published evidence.

The resultant observation schedule was therefore based on real life experiences. The Trust Service User and Carer Research Group had supported the achievement of a significant element of the project's key aim - that is not to ask patients what services wish to know about their inpatient stay, rather to ask them what their experiences have been.

The next three meetings occurred in July, September and October 2012. The format and discussion at these meetings focussed on the initial observations sessions that I had carried out. I was able to reflect my early experiences and check my process out with the group.

I described how despite planning to be an anonymous figure simply carrying out observations this had not occurred, during the time I spent on the ward I very quickly became part of the team. This is discussed in more detail in the remaining chapters, but for the Trust Service User and Carer

Research Group they felt it was significant in terms of developing trust within the ward and patient group, that my presence was significant to patients.

As is discussed later, this was an unintentional outcome that supported the interviews carried out on the open wards and the level of acceptability and familiarity experienced by patients; I feel it had a significant impact on the data I was able to generate.

Key observations discussed with the Trust Service User and Carer Research Group were with regard to the format of the observation sessions, time of day, day of the week and time span of the visits. Reflections were debated and the group felt an ownership of the process. A key addition to my observations was made by one of the Trust Service User and Carer Research Group, to beware of isolating behaviours, that whilst this did not appear on the sheet for recording my observations, following our discussion this may well be an important consideration, I therefore agreed to include some description and analysis of the whereabouts of patients during my observation.

The role and involvement of the Trust Service User and Carer Research Group is detailed within Figure 8, in Section 3.3. Specifically this included the generation of the observation master themes as described earlier in this section and discussion of the observation sessions and analysis of the data from these sessions. This enabled the semi-structured interview schedule to be informed by the observations findings. The Trust Service User and Carer Research Group also reviewed the data and analysis from the interviews, including the 6 master themes and superordinate themes that had been identified.

Finally the Trust Service User and Carer Research Group considered the analysis of the interviews I had undertaken and also the discussion section of this project. The purpose of this was to provide their reflections on the process and outcomes and also to ensure that the conclusions I had generated would have real benefits for patients.

The final meeting with the Trust Service User and Carer Research Group took place on 24th May 2013. The discussion and outcomes from this meeting are detailed within the discussion chapter at section 5.4.4.

Overview of the observations

Observation sessions were carried out on both of the PICUs. In total 16 times 15 minute sessions were completed on six different patients.

I had completed a risk assessment and identified strategies to protect myself as the researcher during the observation sessions, this included a brief handover of anything significant from the clinical team and the adoption of all safety policies that were utilised by them, and specifically this included using the unit's alarm system. Therefore at the commencement of each period of observation I was issued with an alarm and a set of keys.

Following each session I noted anything significant in a patient's presentation or conversation to the clinical team and then I spent time recording my observations.

There was only one occasion when I was required to discuss the clinical presentation of a patient and to recount elements of her conversation with me. The team were aware of some of the contents; but, she had disclosed new information to me and this was fundamental to her care delivery.

In order to support the observation sessions to contribute to the interviews that were to be carried out following transfer to the open wards I carried out the same analysis as that used for the interviews. This, however, was a limiting factor and is further discussed at the end of this chapter, as the timing of the observation sessions and the transfer of patients to the open wards and their re assessment of capacity to be approached to consent to the project was very fluid.

My observation notes and records were subject to:

1. Reading.

2. Initial noting – checking with the Trust Service User and Carer Research Group.
3. Development of any new emerging master themes.
4. Search for connections across existing master themes and new emergent themes – development of super-ordinate themes from the observation.

3.8 Summary

This chapter has described the methodology employed in this research project. The research question has been considered in light of the elements of research and following a review of the elements of research an appropriate qualitative methodological approach has been selected.

Interpretative Phenomenological Analysis and the rationale for why this is the chosen methodology for this project have been outlined. The four phases to the project were described including the rationale and role of the Trust Service User and Carer Research Group.

Engaging patients with mental health issues in research is potentially complex and requires sensitivity to ensure all ethical considerations and regard to their emotional wellbeing is attended to. This process has been outlined including the role of the consultee.

Engagement with the Trust Service User and Carer Research Group has been described including the formulation of the observation topics to be used in phase two of the project.

Chapter 4 - Findings

4.1 Introduction

Chapter four details the findings from both the observation phase and interview phase of the project. Both phases are documented using the identified steps within IPA; these are also outlined in chapter three.

4.2 Observation findings

4.2.1 Overview

The notes made following each period of observation were analysed and then checked through a detailed discussion with the Trust Service User and Carer Research Group. This process identified master themes that were consistent with those initially identified by the Trust Service User and Carer Research Group. The observation findings also provided a depth to these initial master themes and in addition an additional master theme of the *ward atmosphere*. This additional master theme was discussed in detail with the Trust Service User and Carer Research Group. Figure 17 outlines the five initial master themes, plus the additional master theme and also the super ordinate themes noted during the observation sessions and through the subsequent checking and analysis.

Exploration of the observation findings is through these six master themes. The observations made provide a perspective of life on a PICU; however, they vary in time of day and day of the week, I feel this therefore succeeds in providing an overview across time, people and context (Hammersley and Atkinson 2009).

The five initial master themes identified by the Trust Service User and Carer Research Group are:

1. **Gender impact.**
2. **Interaction between patients.**
3. **Rapid changing patient group - dynamics.**
4. **Impact of discharges and admissions.**
5. **Relationship with staff.**

The additional master theme identified through the observation is:

6. Atmosphere

Master themes previously identified by Trust Service User and Carer Research Group	Super ordinate themes
Gender Impact.	<ul style="list-style-type: none"> • Mixing within gender. • Social engagement. • Interaction with staff.
Interaction Between Patients.	<ul style="list-style-type: none"> • Isolation. • Ordinariness. • Music/TV. • Activities.
Rapid Changing Patient Group - Dynamics.	<ul style="list-style-type: none"> • Responses to new patients • Changes in patient group.
Impact Of Discharges And Admissions.	<ul style="list-style-type: none"> • Emotional response.
Relationships With Staff.	<ul style="list-style-type: none"> • Engagement/activities. • 1:1. • Mixing within gender. • Social.
Atmosphere	<ul style="list-style-type: none"> • Calm/relaxed. • Quiet. • Tense. • Noisy.

Figure 17: Comparison of master themes identified by the Trust Service User and Carer Research Group and the Super-ordinate themes identified from the observation

4.2.2 Gender impact

The two PICUs are both mixed gender facilities. The impact of the PICUs being mixed was significant in terms of how patients engaged with each other. There was very little mixing between the genders. This was consistent for both PICUs. Within PICU D I made very specific notes following one observation session indicating there was '*no mixing*' at all. On this occasion I also noted that there was little interaction generally between all the patients.

During other sessions on PICU D I noted significant interaction between the female patients. They had appeared to develop a relationship and were seen to be engaging socially with each other, particularly around their personal appearance and looking at some family photos and mementos that Diane's¹⁵ family had brought in for her. This was supported through observations on PICU R where I noted that Richard and other male patients were interacting together, particularly during time in the outside garden whilst they were having a cigarette. They appeared to be connecting through smoking as a mutual activity. Here the staff also engaged with patients. Whilst this is specifically discussed below, in terms of gender impact I noted that there was an increase in male patients searching out and engaging with male staff and equally so for female patients in their interaction with female staff.

Whilst the two PICUs were mixed gender, there appeared to be a natural separation of the genders in relation to activities and interaction. This is also demonstrated in the next section that describes the interview findings.

4.2.3 Interaction between patients

Interaction between patients varied considerably. This ranged from no interaction and the observation of patients isolating themselves and '*each patient engaged in their own activities*' through to joint groups, discussions and on one occasion the group of female patients discussing Diane's family photos. This group also, during the following session, engaged in

¹⁵ All participants were given a pseudonym to protect their identity.

joint activities in the sitting room. Here they did each other's hair and nails. This included Daisy and Diane. They were already engaged in this when I arrived and continued it during my observation session. When I left the ward approximately half an hour later they were still engaging together in the sitting room. This was the single most pronounced level of interaction and engagement I observed between the patients.

The most frequent observation was that there was little or no interaction between patients, with each engaged in their own behaviours. Due to the nature of the environment there were a number of rooms and spaces for each patient to make use of and I observed all being used. During my return visits it appeared that the same patient occupied the same space.

One male patient spent his time listening to music in the unit's gym. He was observed to spend significant time in here both alone and with staff, but never with another patient. Diane spent a lot of time in the unit's tranquillity room (Faith Room), usually engaging in crafts and writing in her diary. Again she was either alone or with staff and never with another patient during my observation sessions. Rachel spent her time generally on the phone to her family or receiving 1:1 care in terms of diet, physical observations or assessments. Daisy by contrast spent her time generally alone in the sitting room watching TV.

The remaining patients spent time watching TV and listening to music. They discussed the TV programmes amongst themselves and with staff and this contributed to the overriding sense of '*ordinariness*' on both PICUs. This was more pronounced on PICU D, where there was less observation of patients demonstrating psychotic symptoms. Yet, as is discussed within the final master theme, atmosphere, the units generally were calm and relaxed.

4.2.4 Rapid changing patient group – dynamics

As was anticipated, whilst the unit is a short stay facility, there were only a small number of admissions and discharges during the period of

observations. There were no emergency admissions and no section 136 assessments (MHA 1983) during the time I spent observing the units.

The most frequent comment I recorded was that there had been no change of patient. There were two significant exceptions to this:

1. Within PICU D the group described above where the female patients were doing each other's hair and nails coincided with one of the other patients being discharged from the PICU. The patient was one who I had not been able to include within my observation; nevertheless the effect of him being discharged was profound and there was a significant increase in mixing and socialisation.

This may be a coincidence, however, there was only one further observation carried out following this and the change in terms of interaction and mixing was also evident on that occasion. I would conclude that the patient, for reasons I have not been able to explore specifically had a profound impact on the PICU community.

In the interview findings, both Daisy and Diane make reference to their caution regarding the other patients on the PICU and both Daisy and Diane were part of the sociable group following the discharge of this patient. Due to not being able to include him in this project I am unable to specifically draw a connection between these two occurrences, what can be concluded though is that there is an impact of patients on their peers behaviours, socialisation and how they feel.

2. The second was the admission of a new patient to PICU R. He was extremely unwell and displaying florid symptoms. He was clearly hearing voices from the TV and interacting with the presenters on a number of TV programmes. As he was not part of the group I could observe, I could only note the behaviours of the other patients in response to him. However, his behaviour had a profound effect on the existing patients.

The majority appeared to recognise he was unwell and chose to avoid his presence, preferring to spend time in other areas of the unit. Another patient, who also was extremely unwell, agitated and loud, sat with him watching TV. They appeared to be absorbed in their own world and thoughts and I could not perceive an impact of their behaviour on each other.

Unfortunately due to different reasons with regard to capacity, I was not able to interview either patient to establish their thoughts on this episode of care.

4.2.5 Impact of discharges and admissions

The observations and notes with regard to the impact of admissions and discharges are included within the section above with one addition. As I arrived for a session, Richard was in the process of being discharged to an open ward. He expressed sadness and anxiety at leaving the PICU. Both his sadness and anxiety about what the open ward would be like and also his previous reflections at seeing other patients being discharged are included in his interview narrative in the next section.

4.2.6 Relationship with staff

The observation sessions identified positive interaction with staff. This varied between 1:1 time where staff engaged in specific activities; in particular another patient spent time listening to music with a member of staff, and staff facilitating group activities or spending time with groups of patients whilst they were smoking in the garden.

Within the master theme of 'interaction between patients' a super ordinate theme '*ordinariness*' was identified. It became evident within these observations, particularly around the day to day domestic activities, this included mealtimes and the provision of drinks.

Here patients were treated much like a team and staff would seek their preferences for a drink, make them and then bring them to each patient. The same occurred at mealtimes, due to the catering arrangements each

meal was prepared separately for each patient from the food that arrived from the central kitchen, thus all patients were able to have different meals that included their preference and choice and in some instances food brought in by their families. The overriding impression was one that did not reflect a traditional hospital mealtime, where patients would have all been served a meal already prepared on a tray and delivered from a central kitchen.

4.2.7 Atmosphere

The additional master theme added as a consequence of the observation sessions and analysis is that of atmosphere.

Both PICUs varied in level of noise and in terms of how tense or calm the units were. Level of noise did not specifically denote the level of tension or calm.

Within PICU D the first sessions were all very calm and relaxed. There was a low level of noise; this coincided with the patients being engaged in their own activities separate from each other. Largely this continued throughout all the observation sessions, with the exception of when the groups of female patients were engaged in the sitting room the volume of noise rose; however, the atmosphere took on a community feeling and did not seem oppressive or troublesome.

By contrast in PICU R where the patients were generally expressing more disturbed and distressed behaviours, the atmosphere was more changeable.

The noise level was generally higher with more music and activity taking place. Music and the television did on one occasion compete with each other; but it did not appear to impact on the patients and they continued to undertake their own activities.

During one observation session the noise level was quite high and the atmosphere was quite tense in that patients appeared more guarded in their behaviours, were less visible on the unit. This event ties in with the

section (4.2.4) on the changing patient group and was following the admission of a new, unwell patient.

Once the first session was completed the remaining ones did not have this level of discomfort and became fundamental to the remainder of the project.

4.2.8 Benefits and limitations to this phase

Limitations to this phase of the project were the timing of the sessions of observation against patients transfer back to the open wards. The time frame identified in chapter three that was established in order to capture the patients during that phase was very tight to ensure that patients were not discharged and that their stay in the PICU was as recent as possible to ensure the richness of their experiences could be captured. In the main this worked and proved successful; however, it meant that not all the data generation and analysis was possible before the interviews started. The master themes and discussion outlined in this chapter do demonstrate that the initial master themes identified by the patient group in phase 1 held true following the observation; however, I was not able to fully reflect those findings during all the interviews.

A significant unintentional positive consequence was that the time I spent on the PICUs undertaking the observation provided me with an identity to the patients; I very quickly became known and familiar to them.

They accepted my presence and towards the end of the observation sessions I came and went without consequence. Thus once I approached the participants on the open wards to seek their consent to take part in the interview phase of the project I was a familiar face to them and not a new and unknown researcher approaching them.

4.3 Interview findings

4.3.1 Overview

As outlined in Chapter three, the interview transcripts were subjected to the analysis stages within IPA highlighted by Smith et al (2009):

1. Read and re-read the transcripts.

2. Initial noting.
3. Develop emergent master theme.
4. Search for connections across the master themes.
5. Moving to the next case and repeat.
6. Look for patterns across cases.

Through this Interpretative Phenomenological Analysis (IPA) of the four interviews six master themes were identified. This included four key overriding master themes. When the transcripts were further analysed the additional two master themes were each only identified by one participant, this analysis is detailed in Figure 18.

Exploration of the interview findings will primarily be through the four recurrent master themes. Some additional discussion of the two further master themes is included at the end of this chapter. The six master themes and the full list of super-ordinate themes are presented in Figure 18.

The four recurrent master themes are:

- 1. Emotional responses to being cared for in the PICU.**
- 2. Identity.**
- 3. Interaction with others.**
- 4. Search for meaning.**

The additional two master themes, each identified by only one participant are:

- 5. Challenge.**
- 6. Symptom reduction (recovering).**

Through the interviews and data generation and the analysis carried out the interviews represent one aspect and very personal accounts of receiving care in a PICU. Yet the exploration and analysis draws out key aspects that were significant to the individuals immediately after leaving the PICU environment.

The discussion contains extracts from the narratives provided by the participants in order to illustrate the analysis; they have been only altered and modified where necessary to aid understanding and context of the extract. In particular any hesitation and word repetitions have been removed. Where additions have been included for context they are presented in square brackets. Dots signify that the phrase or statement has words removed either at the beginning, during or at the end of a statement.

All identifying information has been removed or changed, and the alias names identified in the methodology chapter have been maintained throughout to protect the anonymity of participants.

Master Theme	Super ordinate Themes
EMOTIONAL RESPONSES TO BEING CARED FOR IN PICU	Anxiety, disbelief and fear. Disorientation/confusion. Gratitude. Frustration, boredom and hostility.
IDENTITY	Role of self. Role of significant others. Role of life experience. Gender. Through illness.
INTERACTION WITH OTHERS	Staff. Other patients. Privacy/personal space.
SEARCH FOR MEANING	Search for familiarity. Search for meaning. Surreal/disbelief. Boundaries/meaning - impact.
CHALLENGE	Boundaries/Restrictions. Choice - lifestyle.
SYMPTOM REDUCTION (RECOVERING)	Staff encouragement. Process of recovery.

Figure 18: Master Themes and Super ordinate Themes

4.3.2 Emotional responses to being cared for in PICU

Through discussion of the first master theme the role and impact of patients' emotions at being cared for in a PICU are explored. Particularly with regard to the levels of anxiety and fear expressed by all the participants, levels of confusion and disorientation regarding time and place, the expressed gratitude during and following their discharge and

also the impact of boredom on their levels agitation and hostility. Also detailed are the frustrations experienced particularly in relation to the perceived connection with their mental health issues. The super ordinate themes were:

1. Anxiety, disbelief and fear.
2. Disorientation/confusion.
3. Gratitude.
4. Frustration, boredom and hostility.

The most significant master theme was anxiety, disbelief and fear; this was expressed through descriptions of incidents with a high level of emotion articulated. From very simple comments made by Daisy that have a profound resonance, '*Felt frightened*', (P.1, L3) to the enormity of the significance of emotion in the experience expressed by Diane.

The following extracts from two separate sections of her interview demonstrate this:

*'I remember waking up if you can call it waking up in the seclusion suite which was absolutely petrifying to me and it reminded me of ... where I used to work'*¹⁶

(P.1, L 10-14)

'I remember the injection, I only remember one injection and being held down and that was terrifying, I remember ... sticking it in my leg, in my thigh and being pinned down...'

(P.2, L 3-7)

Daisy also commented on the emotional impact of restraint and witnessing the acute care of a distressed or disturbed patient:

'The thing that distressed me was seeing people restrained. There were two people at one time being restrained it was chaos, it was awful'.

(P.4, L 15-18)

¹⁶ Diane had previously occupied a role providing supervision for vulnerable adults. This previous experience is referred to intermittently throughout her account.

Diane was very clear in her descriptions of events and was able to remember particular staff who had cared for her in particular events, she could recall who had restrained her and given her an injection and consequently could evoke the high level of emotion she experienced. During her account she did not become distressed and recounted the events in a matter of fact way, whilst she spoke in the first person it felt as though she was shielding or detaching the emotion from herself. However, the second quote went on to justify and rationalise the event:

'...and looking back I understand why they did it to obviously calm me down, to sedate me but for my own safety'.

(P.2, L 7-9)

This reflective observation was also evident in Richard's account where he commented that:

'a lot of emotions come back when you get well'.

(P.3, L 2-3)

Two participants identified fear at not knowing about the other patients on the unit and what they do not know led them to think. This particularly related to their own safety and the emotional impact on themselves. I recorded this as anticipated fear. It was most significant for Daisy who returned to this issue on a number of occasions, she commented that it was:

'Very distressing really, newer people with different illnesses, didn't know how to respond'.

(P.1, L 20-22)

She had a relative who had also spent time on a different PICU and as such the concept of being cared for on a PICU was not new, but the stuff of legends:

'It was different, not been to a place like that before, heard stories about it but the stories made it 10 times worse than it actually was'.

(P.2, L 19-21)

Diane was more logical in her thinking and in keeping with her emotionally disconnected way commented on the other patients:

'I would think sometimes will they, are they a danger to society because of, are they a rapist or a paedophile, that goes through your head'.

(P.8, L 7-9)

The hesitation around 'will they' implies she may be considering their actions as if they were a rapist or paedophile, but resumes the statement by referring to the wider society. Diane was generally anxious and displayed over activity; however, her comments through this section demonstrate a significant amount of consideration to fears and safety but little acknowledgement that the fears are hers.

As a continuum to the anticipated fear from Daisy she also commented:

'when new people came it made me wonder what was matter with them, if people had had Schizophrenia I would've been frightened, not because I am ignorant, just don't understand it'.

(P.2, L 6-13)

This comment appears to distance her from other patients, using the word 'them' implies she does not see herself as one of them; conversely, later in her interview she describes other patients as being her friends as well as identifying the social aspect to the PICU.

A further feature that arose in two interviews was the levels of distress at being cared for in a PICU and different levels of understanding. Both Daisy and Diane experienced this. Diane with an emotionally pleading:

'you are so desperate to speak to them [the doctors] and say but what's wrong with me?, what's wrong with me?'

(P.4, L 26-28)

Whereas Daisy believed she should be cared for elsewhere:

I didn't like it just wanted to get out and go to my family, I didn't belong there, not at all. That time that distressed me'.

(P.5, L 7-10)

This ties in with her comment about 'them' and that the PICU is for other people, not herself.

Three of the four participants' highlighted disorientation and confusion as a key aspect to their experience in PICU, two of those had been secluded during their stay and it was during and following the episode of seclusion that they experienced the most disorientation.

Diane was admitted straight into seclusion and from this experience commented:

I can't remember a great deal for the first week/10 days to be honest.... so on top of being in there and not knowing why I was there I didn't even know the date, I can remember looking at the clock and seeing Friday and I saw Saturday and I saw Sunday, saw Monday and Tuesday..'

(P.1, L8-9. P.1, L 22-27)

This was significant to Diane; the fact that she was 'missing time' had a negative impact on her. She further described this through not being able to remember seeing her family:

'and not seeing your children and not seeing anybody that you know or not even remembering seeing anyone that you know, because they have obviously been there to visit you... but you are not aware of this'.

(P.2, L 14-18)

The inability to recall this time was powerful for Diane, by contrast Rachel was less concerned about the passage of time and impact it may have had on her:

Deb: When you spent some time in seclusion was that overnight or during the day?

Rachel: I think it was a day or something like that.

(P.2, L 2-4)

Deb: Did you feel that you were clear about the day of the week, the time of the day?

Rachel: No.

Deb: How did you find out what time of the day or week it was and that kind of thing?

Rachel: If I asked someone.

Deb: Did you feel that you wanted to know that?

Rachel: Sometimes but not all of the time.

(P.6, L 8-17)

The nature of Rachel's interview was in keeping with this extract, she was less concerned about her care, time and events external to herself.

The third participant who experienced this disorientation was Richard. For him this was not connected to spending time in seclusion but to isolating himself in his bedroom. He identifies this as self imposed through his illness and ties it into his levels of gratitude towards the staff for encouraging him to mix and socialise, thus addressing the issues of disorientation:

Deb: Did you feel as though you knew where you were, the day, the time?

Richard: No not really, I knew where I was but I was losing track of days and time and things like that but staff started to encourage me to come out more.

(P.2, L 6-11)

The notion of gratitude was expressed in different ways for three of the participants.

Richard was able to identify the impact the staff had had on him during his stay and reflected back to the time he spent on the PICU, he commented:

'Staff on there are great, encourage you coming out, they were praising me when I did come out of the room and just

things like that, just encouragement for me to coming out a bit more, it was brilliant'.

(P.1, L 18-22)

He expressed his appreciation on an ongoing basis and in his interview his non verbal communication demonstrated his wonder at becoming better and moving his life on, he was quite amazed at being discharged from the PICU. I am left not knowing if this was a short lived emotional response to relief at his discharge from the PICU and if once he spent more time on the ward or at home that this would dissipate and he would potentially slip into a depressive state.

By contrast Diane was more measured in her responses and discussion; she described recognition of the staff role during her time in the PICU:

'the men were reassurance, father figure, a brother figure'.

(P.6, L 8-9)

'... did my hair, with her curlers and things, you know that was great stuff just to feel like you are a woman again'.

(P.10, L 11-13)

'... I thought this can't be real, so it's great for you but you are thinking this is too good to be true you know, there is a member of staff sat here and I could be [with] a manicurist paying a lot of money for it, but the feeling, you just can't beat that feeling, it gives you a boost as a woman'.

(P.10, L 15-21)

Similar to Richard, she also identified:

'you just can't thank them enough.(P18, L 29), I do miss [the staff] and would like to say hi, thanks, look at me now, thanks for what you did to me'.

(P.19, L 1-3).

She states 'what you did **to** me' rather than **for** me. This is significant in terms of the detailed account she gave of being secluded, receiving medication without her consent and her emotional response to this, it echo's her earlier statement where she rationalised and justified the staff intervention and seclusion.

In contrast to this Diane also describes wanting to give back following discharge, she expresses her gratitude and desire to help others by seeking voluntary work:

'Yeah I want to come back, I want to do that [voluntary work] because I have enjoyed doing that, and I have gone round specifically to PICU and ripped all the weeds out'.

(P.14, L 18-21)

Daisy's gratitude was more restrained, she had as previously identified been told stories about the PICU, when in fact she concluded:

'[I had an] Image in my head – plastic knives and forks, not allowed any of my stuff, no fags etc, can't believe I was there I thought staff would be nasty'.

(P.2, L 22-25)

'... Loads better, nothing like any of the stories'.

(P.3, L 6)

The final super ordinate theme within the emotional aspects of being cared for on the PICU was frustration, boredom and hostility. Daisy highlighted a number of issues here; however, they also link to an additional master theme of Challenge around boundaries and choice. Rachel expressed this through her frustration at being treated like a child:

'Staff was good to me I think, just a few treat you, I don't like it when I am being treated like a kid'.

(P.2, L 19-21)

She expressed this in a more profound way by drawing an analogy between being treated as a child and her mental health issues,

'I am a grown up so, I might have mental issues but I am grown up..., I was asking for a cigarette, I wanted them to buy me cigarettes, I had £10, they said to me no, can't buy you cigarettes because you are pregnant. This is my life you can't tell me what to do, I know I can control myself, but I want a cigarette'.

(P.3, L2-10)

There are a number of considerations in her statement, firstly the content, alternating between **them** and **you**. Indicating either a shift in her conversation or how she viewed me as the researcher or staff member. Secondly that of choice and wider issues around health promotion and the role of staff.

Daisy also highlighted this in a conflicting manner, whilst she understood the need for safety as not having all her belongings, she also believed she was of an age where she found it difficult to tolerate:

'Understand why safety etc... I thought I am 30 years old don't need this'

(P.3, L 11-12)

Richard drew a connection between his levels of agitation and boredom: *'I was a little bit agitated because I was a bit bored'* and also the impact this has on levels of hostility:

'It can get quite hostile, obviously there isn't a great deal to do on there, you have got a lot of time to think about on there'

(P.2, L 23-26)

The greatest thing he would change is the levels of activities to address the boredom:

Deb: What is there on the ward that you would want to change or be different?

Richard: Just the boredom really, like I said a few more activities.

(P.11, L 1-4)

4.3.3 Identity

The second master theme explores the role of the self to the participants, the role and impact of others including staff and families, the impact that previous life experiences has on them and how they identify themselves through their and other patients gender and also through their illness and

diagnosis. Three out of four participants expressed observations or comments relating to their identity. The super ordinate themes identified within this master theme are:

1. Role of self.
2. Role of significant others.
3. Role of life experience.
4. Gender.
5. Through illness.

The super-ordinate theme of the role of self is about how participants viewed themselves within the context of being cared for in a PICU. Diane particularly identified this, when an incident occurred on the PICU she reflected:

'I learned to think it's nothing, the staff are in control, they can go, it's not my job, I am just a patient'.

(P.17, L 12-14)

She describes throughout her account her previous role in a position of responsibility for others, her reflections and descriptions of episodes of disturbance and noise include:

'...Yeah and thinking you are running to save a colleague or are you running to save a patient and all those bad things I saw, traumas and nasty things resurface and to even to some extent on this ward it is still the same'.

(P.17, L 7-12)

In her disorientation and confusion her previous employed role and where she is at the current time blend into one, she struggles to differentiate the two. The events that are occurring on the PICU have direct impact on her even though she is not involved in them. This is also evident in the narrative of Daisy where she describes the impact of seeing another patient being restrained. The difference between the two accounts is that Daisy identifies with the patients and their predicament whereas Diane thinks back to her role as a staff member and identifies with the responsibilities held by that role and consequently the ward staff.

Hence the more conscious thinking Diane expressed: *'I am just a patient'*(P.17, L 13-14).The implication is that she views herself as secondary; it was not expressed with relief, but regret that her previous employment is a world she no longer occupies. Her desire to align herself with the staff and perhaps her old life came through significant elements of her account.

Diane continued to express a desire for knowing why she was in the PICU, it was evident that she struggled to reconcile why she needed to be cared for in an intensive environment and again the confusion between this and her previous experience of working in a secure environment was apparent, she was anxious to receive a diagnosis, and appeared to need this to validate her stay. Her account implied relief to receive a 'diagnosis' of a breakdown, in reality it would be unlikely that this diagnosis would have been given, never the less for Diane it signalled confirmation that she had not committed an offence :

'look you are OK, we are going to diagnose that you have had a breakdown you are not in here for doing anything wrong'.

(P.20, L 21-24)

The next super-ordinate theme explores the role of significant others. This was different for all participants. Rachel, during the observation sessions spent significant amounts of time on the phone with her family and received a visit during one session, did not identify it as significant in her interview. When asked about having many visitors, she drew comparison to the open ward indicating that the increased freedom was better:

Deb: Did you have many visitors whilst you were there?

Rachel: Yes I did, my aunts came, my cousins came.

Deb: were your visitors able to come when you wished them to be there?

Rachel: [open ward name] is nice, I have my phone and my freedom.

(P.5, L 18-24. P.6, L 1-2)

Rachel was not explicit in her views about her visitors; however, as discussed earlier she did experience issues with the boundaries and freedoms afforded to her. Therefore through this extract I have concluded that her thoughts after only a week on the open ward were focussed on the benefits of that ward and that the experiences on the PICU were already starting to fade from her memory. For example the restrictions she experienced with regard to smoking would not be in place on the open ward, she would be able to access cigarettes without the control of the nursing team.

Within Daisy's account the role of significant others differed to Diane and Rachel. Her experiences were influenced by events in the past. It was apparent through the interview that her previous knowledge of the PICU had been heavily influenced by her brother who had spent time being cared for in a different PICU. She had:

'heard stories about it but the stories made it 10 times worse than it actually was'.

(P.2, L 20-21)

The exact detail of what she expected it to be like could not be gleaned from Daisy, despite this, she shared that it was:

'because my brother was on a PICU and the staff were nasty'.

(P.2, L 25. P.3, L1)

That *'it was not around here'* was what she put down to her experiences being radically different to her brother's.

Richard by contrast was influenced by the experiences of other patients on the PICU, he was positive about other patients and interactions and throughout his account enjoyed the social nature of the PICU, he referred to the gender mix and the influence women had on men's behaviours and the bonding of the men on the unit, discussed later he experienced the meeting of new people as positive:

'you get to meet new people and everything'.

(P.3, L 8-9)

Diane spoke intermittently but consistently throughout her interview about her role as a mother and wife. Her children were shown to be central to her whole being, all conversations lead back to them and how they perceived her and her illness, what she was doing and her absence from home.

This was expressed in a highly emotive and distressing way:

'when you have got some adrenalin pumping through your body and you are fighting for your children and not seeing your children and not seeing anybody that you know'.

(P.2, L 11-15)

She recounts her need to see her children and her intense desire for them to visit her; however, this was countered by her knowing that she was unwell and her insights into her behaviour.

During the account I was acutely aware of her recognition of her illness and behaviour and her frustration at not being able to control herself, as though she was in juxtaposition of knowing how unwell she was and that knowing it hindered her ability to function. She recounts an occasion when the children visit her, describing it in the third person:

'they [the children] are just looking through a glass window and there's mum there with hair flopped over her face and acting like a crazy person, not knowing she has had a breakdown'.

(P.2, L 19-23)

This serves to underline the conflict Diane experiences between herself and her 'ill' self, recounting 'mum' who does not know she has had a breakdown against who she is now and realising she has been/is unwell. She continues to identify the impact her illness has on both herself and her children:

'it feels like a life time away from my boys and it feels like I have so much ground to make up but you know they just

love me for who I am and I feel it for them because people say your mum is a fruit bat, I don't care what people say, but to my boys there is a stigma attached'.

(P.15, L 25-27. P.16, L 1-4)

Life experience was a super-ordinate theme raised only by Diane. She had previous experience working in a secure setting and drew on this throughout her account. She made reference to an array of events and occurrences:

'I have gone through the ... service and I have seen lots of things'.

(P.3, L 5-7)

At no point did she expand on what the 'things' were, she did not appear to be consciously shielding them, indeed she was very open and talkative, more it was that the events she referred to had caused a depth of trauma and therefore whilst she knew they had happened the detail had been wiped from her conscious mind. She did display deep consideration about the impact any discussion or conversation she raised with other patients may have on them and their previous history and life experience:

'it is difficult sometimes to talk about things because if you say something about your dad, or that my dad passed away and I grieved over him but they may have been molested by their parents'.

(P.11, L 4-9)

Gender and the mixing of both men and women in the PICUs were of significance for all three respondents for whom this was a recurring super-ordinate theme. However, how it was expressed was quite different.

Richard viewed the role of gender as the interaction between both sexes and the moderating effect he saw women had on men. On several occasions he highlighted this:

Deb: what impact did the fact there were women there have when you were so unwell?

Richard: I think it encouraged me to come out a lot more to be honest, when I was in bed I didn't get to know many people, but

women and males, it's different when it is all lads because you have a lot in common, you know what I mean, where different females get's you to think different strategies really, thinking about different coping strategies and that. I think it makes it a little bit calmer as well because obviously you not wanting to kick off as there are females there.

(P.3, L 11-25)

An additional comment made by Richard, '*You get to interact more with females and males*'(P3, L 9-10)demonstrates that being cared for alongside women was significant to Richard in his everyday engagement, his account did not identify concerns with this, but repeatedly identified the effect being with women had on him and his behaviour. Would he have, or would his male peers have, 'kicked off' more if women were not around?

Through these comments and others made about males bonding he demonstrates a very different perspective on the role of men and women. His experiences of being cared for on the PICU have been influenced by this and the fact that the unit was mixed. Without knowing more about his background and previous care it is impossible to identify the rationale for this; but, in keeping with the central aim of this project - to understand the experiences of being cared for in a PICU, it is sufficient at this stage to maintain the analysis at this level and to understand the impact of his current care.

By contrast Diane saw the impact of her gender very personally and how she felt being a woman. This related to her own safety: '*being a female you do tend to worry.... but there was enough staff on*' (P8, L 3-5) against her own experience working in a similar, but different, environment: "*... and me coming from a background I would think sometimes will they?, are they a danger?*' (P.8, L 5-7)

This was echoed by Daisy, whilst the rationale was different in that it had arisen from stories from her brother and others and not from experience, she still held fears for her own safety from the men on the PICU:

7 felt frightened - shouldn't be mixed. Women were fine, man made me uncomfortable, got on with women, I think

because two of them have same illness as me so understood each other a lot.

(P.1, L 3-7)

The view from her that she 'got on' with two of the women also links to the next super-ordinate theme - identify through illness. Daisy identified with key patients on the PICU when she recognised that they had the same symptoms as herself. She terms this as the same illness. However, I felt that what may have been occurring was that she was seeing similar patterns of behaviour that she was able to identify with.

Richard also identified that women need to talk to women and conspiratorially indicated that there were specific things women needed to talk to women about, he could not be drawn on what these were and so the subject was left:

'I think female staff and female patients are a good thing because it's not all males and obviously females need other females to talk about things'.

(P.8, L 25-28)

The final super-ordinate theme in this master theme is that of identity through illness. As with previous sections there was a difference to how participants identified with this, from an internalisation about the journey their illness had taken:

'because I have attempted suicide in the past, after my first baby, I had post natal depression, and I had post natal depression with my second'.

(Diane: P.3, L 25-28)

and the impact it had on their current need for the PICU care to how participants were able to interact with other patients as a consequence of illness and their symptoms:

'Two other patients fine, another I didn't get on with because she was really poorly, couldn't understand what she was saying, other two had same illness as me'.

(Daisy: P.1, L 16-19)

By contrast Richard identified that how you are feeling within yourself at that time impacts on how you are able to communicate and interact with other patients and not **their** symptoms:

'how well you can connect to people and how well you can to talk to people, how easy it is for you, so it all depends on your mental health state as well'.

(P.7, L 3-7)

4.3.4 Interaction with Others

The third master theme - interaction with others, is explored through the accounts of all four participants. This section aims to reflect their accounts of the role and the significance of interaction with the staff on the unit, other patients that were also there during their stay and their reflections on privacy and personal space.

The super ordinate themes identified within this master theme are:

1. Staff.
2. Other patients.
3. Privacy/personal space.

All participants commented on the role and impact of staff and their interaction with staff. Diane identified that staff were different during the time I was not on the ward; however, when exploring what it was like when I wasn't there she commented that they were *'Fantastic, really, really good'* (P6, L5).

This positive view was reflected by Richard also who commented:

'Staff on there are great, encourage you [to come out], they were praising me when I did come out of the room'.

(P.1, L 18-20)

Daisy identified that she felt supported and also cited the increased contact as being significant in her interaction with staff:

'Staff made you feel welcomed and always there to talk to you. You get 2 1:1's a day and only 1 on here [the open ward]'.

(P.5, L 11-13)

Daisy also expressed views about what the staff interaction was like, identifying that it was similar to day to day conversation, not focussing on 'illness', she observed there was:

'easier, normal conversation, easier on all of us, rather than 'how are you?'

(P.3, L 13-15)

This concurs with the observations I carried out and the master theme of 'ordinariness' identified, that interactions, conversation and behaviours had 'everydayness' to them.

Further excerpts regarding interactions with staff were related to the development of a friendship or bond. In describing different relationships with different staff Diane indicated she believed she *'made friends on there, with people, I made friends with staff as well'* (P8, L 18-19). She continues with the friendship topic:

'there is quite a lot of staff on here, you sort of build friendships and some you sort of get on with and their help to get better but you just can't thank them enough'.

(P.18, L 26-29)

By connecting gratitude with friendship it is difficult to establish her understanding of friendships; the importance of making friends, however brief and engaging with staff on a personal level is clear.

The importance of this and significance of staff relationships is further supported by the comments made by Richard, here he describes the staff as a whole group, he demonstrates this as a whole group alongside singling one staff member out as found within Daisy's account:

Richard: Well I have got a real good bond with staff.

Deb: What all of them?

Richard: Absolutely everyone of them. All I wanted I could go to the staff, especially one lad called ...on there,

(P.8, L 2-7)

Whilst good staff relationships were clear through the accounts, both Rachel and Daisy demonstrated some ambivalence. Rachel commented:

'Staff was good to me I think'.

(P.2, L 19)

She was not really sure, this is also evident in her account generally and her recall of her time spent on the PICU was less than the other respondents, she demonstrated more isolative behaviours both in the observation and also as a running subject through her account of her experiences. She seemed to distance herself from events and activities.

Daisy had a changing relationship with staff:

I get on well with all staff, apart from one at first. I got really upset with them on my first day, but did get on with them after that. Could've done without it was really frightened of the place, I got upset, and started shouting'.

(P.2, L 14-18)

This underlines the importance of staff developing relationships with patients, that the developing relationships was absent from both Diane's and Richard's accounts may be explained by their isolation from the main ward during their early days on the PICU, Diane through seclusion and Richard through his self imposed isolation. Patient to patient interaction featured within the accounts and the supportive role of this. Richard identified the low number of patients as being significant:

'we got quite close, there were only five people there at a time on there so you get quite close to people on there, you get good friends, depending on how much time you are with them really'.

(P.6, L 19-23)

Richard through: *'team bonding things like that, Well what I call team bonding skills is having a game of cards, or guess who or things like that'* (P.4, L 21-24) underlined the importance for him in the patient group spending time together, engaging. He, once he spent time out of his room, was a very sociable person on the PICU and extremely grateful for all the care he received.

Diane goes further and describes different levels of friendships:

Deb: You made friends with all the patients?

Diane: Yeah, with all, I don't know you just make little friendships and some friendships are better than others, I mean I remember when came across she was really, she likes to call Little Tigger out of Winnie the Pooh because she was like bouncing around, I mean she cried eyes out when I left but I had to do it, I had to move a step closer to getting home'.

(P.8, L 20-30)

An alternative to talking to staff was evident in Daisy's account:

'if I found it difficult to talk to staff, talked to patients instead, I think it is easier when people know what you are going through'.

(P.1, L 7-10)

Daisy underlines this with the comment that:

'they [the patients] were my friends'.

(P.1, L 7-10)

This was expressed after having only spent a few days on the PICU. This could describe the fleeting nature of developing friendships in such an environment or be illustrative of the intensity of the nature of the PICU environment.

This along with the interactive nature of Richard's and Diane's account identify the importance of the role of other patients for each other on the PICU.

Rachel by contrast was more circumspect in her description of her relationships with other patients, simply stating:

'The other patients were all right'.

(P.3, L19)

The third super-ordinate theme was patients' accounts of personal space and privacy. This super-ordinate theme was highlighted only by the female participants and related to their bedrooms and personal care, in particular, Daisy commented:

'When I first went to the room it was awful, no curtains, no shower curtain, They said it was for my own safety, (P.4, L 1-3).. It was awful having a shower with no shower curtain, with the window with nothing up at the window'.

(P.4, L 8-10)

This coincides with the difficulties she experienced in communicating with the staff when she first arrived on the PICU and appears to be a significant time.

Diane also experienced issues with regard to privacy and her bedroom, she did not describe who 'they' were, staff, patients or anyone else. However, the key issue is that she experienced issues with regard to her privacy from others.

'I daren't get in that shower, what happens if they come into my room?'

(P.8, L 11-13)

The availability of a personal private space was noted by Rachel, again in her straightforward, clear way:

'there was a private lounge, it was nice'.

(P.8, L 19-20)

4.3.5 Search for Meaning

The fourth master theme aims to capture and describe the participants' attempts to understand why they are in a PICU, what it means, how they have arrived there. This includes their search for meaning of the experience, feelings of it being unreal and disbelief, and what the impact of the boundaries imposed on them have. The super ordinate themes were:

1. Search for familiarity.
2. Search for meaning.
3. Surreal/disbelief.
4. Boundaries/meaning – impact.

The search to understand and make sense of being in the PICU was expressed by Diane where she was able to connect the emotion she felt whilst in the PICU and her attempts to make sense of her experiences with phrases such as:

'I was thinking I was in a prison cell'.

(P.1, L 14)

'I just wanted to escape and that was rooting around my head thinking I've done nothing wrong and I haven't hurt anybody so why am I here?'

(P.1, L 15-19)

The search also brought past memories to the fore:

'and so from working in the ... back in ... it set off, that triggered a lot of things I had counselling for in the past. It brought them all back to the surface'.

(P.1, L 19-22)

Within Diane's account she expressed her thinking around having done something wrong that has resulted in her being on the PICU, this is also echoed in the second master theme - Identity.

She further described it here:

Diane: you are not in here for doing anything wrong ... that is what it felt like.

Deb: Yeah. So you thought you had done something wrong?

Diane: I thought if I have someone would walk up to me and say you have done something wrong on that date.

Deb: But no-one has yet?

Diane: But they shouldn't do because I can't remember, and if I did do something I am sorry.

(P.20, L 23-30. P.21, L 1-4)

Through this aspect of Diane's account and in her search for meaning she explores that she must have done something wrong to be in the PICU. Whilst she seems to understand that she is on the PICU because she is unwell, the thought that she may have done something wrong does not leave her, resulting in her apologising for a mythical wrong doing.

Diane referred to certain aspects of the time she spent on the PICU as being unreal; this was best described when she came out of seclusion and returning to the PICU ward:

Deb: When you came out of seclusion what did it feel like going out to on a ward?

Diane: Surreal again, but the ward was calming, there were things on there to do.....,

(P.4, L 16-19)

However, it was also of significance that when describing her family and children, she was confused about what she had done and connecting the mythical wrong doing to how she had ended up in the PICU away from her children:

'I never talked much about ... because it was in my heart and that was too painful and I am thinking where are they and what I have I done ... and I think this is unreal and you know, just to touch them didn't feel real'.

(P.4, L 31-33. P.5, L 1-4)

Boundaries and restrictions that are a necessary part of care in a PICU were described by Diane and Daisy through their search for meaning to the experience. Both struggled with the impact the restrictions had upon them. This was expressed in a different way to Rachel who articulated frustration at the restrictions and boundaries and the impact on her choices. Diane and Daisy were more philosophical, this is demonstrated by Diane in her discussion around her children:

'there's that table and chairs that are not utilised and you could just open the gate, and I used to sit there so many times and just peak through the gate, the gap in the gate and look and think, oh, if I could just sit there with the children and have a little visit, and I wouldn't run off anywhere'.

(P.13, L 25-30. P.14, L 1)

Daisy was more all-encompassing in her view of the restrictions:

Deb: Not having your stuff – what did that mean?

Daisy: Everything really, always being used to having around me.

(P.3, L 8-10)

She did not express frustration, she, during the interview, was more passively accepting, but that it was *'everything'* to her was significant.

4.3.6 Challenge

The master theme of challenge aims to reflect the frustrations felt by participants in relation to the boundaries and restrictions that were in place and seen to be imposed on her whilst in the PICU and also the role of choice with regard to her lifestyle. This master theme was present in one respondent; however, it was a significant master theme for her and consequently was identified through analysis as a master theme. The super ordinate themes were:

1. Boundaries/Restrictions.
2. Choice - lifestyle.

Whilst this was pertinent for Rachel, it also allowed a higher level of analysis to be carried out in the previous master theme, 'search for meaning' that led to the identification of shared concepts and a commentary with regard to boundaries and restrictions for both Diane and Daisy.

Within this master theme, Rachel's accounts of boundaries and restrictions and the impact on her lifestyle choices are represented. Rachel particularly felt frustrated at being restricted in her lifestyle choices, expressing this through an analogy of age:

'I don't like it when I am being treated like a kid'.

(P.2, L 20-21)

The discussion with regard to smoking and purchasing cigarettes frustrated Rachel further. She was clear that her mental health issues did not impact on her being able to understand the issues and her ability to make such choices:

'I make sense or whatever they are asking for'.

(P.3, L 3-4)

When Rachel expressed the view '*This is my life you can't tell me what to do; I know I can control myself*' (P3, L 8-9) it wasn't with regard to her mental health and behaviour, she did not raise any issues with regards to her being detained and undergoing compulsory treatment; however, she did wish to maintain control over different and, for her, equally important elements to her life:

Deb: so the choices you wanted to make.

Rachel: I wanted me to make it on my own.

(P.3, L 12-14)

This was further demonstrated when she referred to the open ward in her account, she drew analogies between the PICU and current ward:

'Freedom, it's open, unlike ..., it is closed up, you can't go out'.

(P.7, L 21-22)

Drawing a contrast between other participants and their reflections on the amount of time staff spent with patients in the PICU to the freedom and choice of the open ward. On the open ward Rachel would have been able to secure her cigarettes through other patients and staff would have less knowledge of her smoking activities.

4.3.7 Symptom reduction (recovering)

The final master theme aims to capture the role of the significance of symptom reduction (recovering) during time being cared for in the PICU. This includes the role and function of 'staff encouragement' and also the 'process of recovery 'through experiencing a reduction.

The super ordinate themes were:

1. Staff encouragement.
2. Process of recovery.

Richard was the only respondent, who through analysis highlighted the role of symptom reduction (recovering) in his experiences on the PICU. This has been included as a master theme given the significance for him. I was present on the PICU as he was being discharged, I was therefore able to have a brief discussion with him about my project and that once he had settled into the open ward I would approach him to discuss an interview. He immediately agreed and subsequently the approved process for establishing capacity and consent was followed on the ward. In his interview he described how the role of the staff had been crucial in his recovery. This was also evident when he focussed on the role staff played in motivating him:

'Staff on there are great, encourage you coming out, they were praising me when I did come out of the room and just things like that, just encouragement for me to coming out a bit more, it was brilliant'.

(P.1, L18-22)

Richard had isolated himself in his bedroom, whilst I do not have the details of why this occurred, he attributes being supported to mix with other people and engage in activities as significant in his recovery from the acute phase of his illness, citing the staff team and their approach as being key in this, for himself:

'...and just basically praising me every time I did [engage in activities]'.

(P.2, L 14-15)

'It's down to individuality...you know what I mean, it's your mood, mental health state, individuality'.

(P.12, L 11-13)

And also in regard to other patients on the PICU:

'they have worked wonders with me, other patients I think they work wonders with them as well'.

(P.12, L 7-9)

The journey from this isolation to one of looking towards discharge was also evident when he described how it felt seeing other patients being discharged:

'bloody hell I have been on here quite a bit of time when is it going to be me. Other people were going, and I was thinking why not me?'

(P.5, L 22-25)

4.4 Summary

This chapter has presented the analysis and findings from phases two and three of the project.

For the observation phase this centred on the planned five master themes with one additional master theme identified through the process of the analysis. Key observations that came through the analysis were the ordinariness of the units, the fact that most patients spent significant time

alone engaging in their own activities or mixing within their own gender and the impact on both these aspects that a change in the patient population can have.

Also significant was the interaction with staff and that most patients interacted with staff of their own gender. Finally, the new master theme of Atmosphere was discussed. This included the changeability of the atmosphere and its relationship to the level of noise and activity within the unit.

My reflections on this phase were considered. Most significant was the timing of the observations sessions and the ability to immediately move to interview those transferred to the open ward before the observations had concluded.

Also noteworthy was the unintentional positive consequence of being known to the patients, this I feel was an enabling factor in seeking their consent to carry out the interview within phase three of the research.

Analysis of the interviews identified six master themes. The most significant were those of the emotional response to being cared for in the PICU, patient's identity and how they see themselves in the context of the family, their illness, life experience and through their gender. Also central was the interaction between patients and the fluctuation in how they engaged. This varied from a high level of engagement and sense of identity between patients to a feeling of anxiety and fear at the unknown aspects of other patients.

Some patients also searched for a meaning to their experiences and endeavoured to utilise familiarity and the boundaries imposed to understand the experience of being cared for in the PICU.

The final two master themes of challenge and symptom reduction (recovering) were only identified by one participant each. Challenge was seen where the boundaries of PICU were too restrictive on the participants

lifestyle and she identified a frustration and the impact being in PICU had on the choices she was able to make in her life.

Symptom reduction (recovering) was also significant for one participant, here the role of staff in encouraging him to respond to a lessening of his symptoms and the process this had in his recovery was highlighted.

CHAPTER 5 – DISCUSSION OF THE FINDINGS

5.1 Overview

Through the illumination of patients' experiences of psychiatric intensive care and exploration of the meaning that patients ascribe to their experiences of psychiatric intensive care, this project sought to examine:

'By their own account, what are patient's experiences of their care during their time spent in a Psychiatric Intensive Care Unit?'

This was completed through observation of patients whilst in a PICU, followed by semi-structured interviews and analysis using Interpretative Phenomenological Analysis (IPA).

There has only been one previous qualitative study carried out to examine patient perception and satisfaction with PICU services (Wykes and Carroll 1993). That study, however, did not allow patients the freedom to tell us their stories as they wish them to be heard, rather as in keeping with other approaches feedback has been obtained from the focus of services and not from the voice of those experiencing care.

The analysis of both the observations and semi-structured interviews within this project revealed a number of master themes.

From the observation analysis:

1. Gender impact.
2. Interaction between patients.
3. Rapid changing patient group.
4. Impact of discharges and admissions.
5. Relationship with staff.
6. Atmosphere.

From the interview analysis:

1. Emotional responses to being cared for in the PICU.
2. Identity.
3. Interaction with others.
4. Search for meaning.

5. Challenge.
6. Symptom reduction (recovering).

The last few years has seen a change in the culture of the NHS. This has been in part demonstrated through an increasing prominence in policy, practice and research about the significance of patients experience of care (DH 2005c; Darzi 2008; DH 2007b; DH 2008b; DH 2009b; DH 2013). This is evidenced in the volume of documents and approaches to emphasising the impact of high quality care and the role of service users in establishing what constitutes quality care from their perspective.

For example the NHS Constitution states in its opening paragraph that *'The NHS belongs to the people'* (DH 2013). Also included is the powerful statement that the NHS *'touches our lives at times of basic human need, when care and compassion are what matter most.'*(DH 2013, p. 2). This could rarely be truer that when caring for distressed and disturbed patients with acute mental health needs.

In addition, poor quality care and lack of compassion have become the focus of media attention (Maben et al 2012). Several events have prompted this. These include the abuse that occurred at Winterbourne View hospital, which was examined through a serious case review report¹⁷ and also the findings of the second Francis Inquiry¹⁸ that reported in February 2013.

¹⁷ Following transmission of the BBC Panorama *Undercover Care: the Abuse Exposed* in May 2011 which showed unmanaged Winterbourne View Hospital staff mistreating and assaulting adult's learning disabilities and autism, South Gloucestershire's Adult Safeguarding Board commissioned a Serious Case Review. The review covered the period from January 2008 - May 2011. The abuse was substantiated and the review made a number of recommendations.

¹⁸ The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013) is the second independent inquiry into failings in the provision of healthcare at Stafford Hospital, part of Mid Staffordshire NHS Foundation Trust. The report, published in February 2013, highlighted significant evidence of poor care at all levels of the organisation and in the wider NHS. A considerable number of recommendations were made.

It is against this backdrop of poor practice and the prevailing agenda of developing high quality compassionate practice that puts patients at the heart of their care, that the discussion in this chapter is focussed. The master themes that I consider to be most relevant to the advancement of intensive care and clinical practice and where the patient voice can be most heard have been selected to frame this discussion. This includes three master themes that arose from the interview analysis and also an additional master theme of 'atmosphere' that was identified through the analysis of the observations sessions.

This additional theme from the observation sessions has been included in the discussion chapter as it had not been previously identified by the literature as a key topic, not been highlighted by the Trust Service User and Carer Research Group and yet appeared to influence the experiences and behaviours of the participants. This was in relation to the calmness of the unit and how this impacted on patient's experiences. The first PICU appeared though the observations to be most calm, yet it was here that patients expressed a higher level of anxiety and anticipated fear about what was going to happen.

The first section of this chapter will discuss key issues arising from the master themes in light of pre-existing research and literature. From here this Chapter describes the significance of the study, the implications for practice, methodological considerations including limitations to the study before making recommendations and identifying areas for future research. Finally my reflections on the study are explored, including plans for the dissemination of the study and findings.

5.2 Findings in light of existing literature

The considerations in the first section of this chapter have taken me back to the literature. As supported by Smith et al (2009) this includes that outlined in Chapter three and also 'into new and unanticipated territory'

(Smith et al 2009, p. 113) in response to the master themes that emerged. This has been done in a selective and not exhaustive manner, using that which is particularly resonant to this study and its parameters.

5.2.1 Emotional responses to being cared for in PICU

Anxiety, disbelief and fear

Admission to a PICU is an emotional experience (Kingsley 2008). Current literature that identifies the impact of admission focuses on the nature and reason for admission (Beer et al 2008). This includes the patient's diagnosis and the reality of having a psychiatric illness but does not include the emotional impact on the patient of being exposed to an environment, activities and behaviours they do not understand, potentially have not experienced before and may not believe they require.

In this study the most profound emotions expressed by participants were *anxiety, disbelief and fear*. Both Daisy and Diane expressed fear of being cared for in PICU. The sense of fear was heightened by receiving care that they did not understand they needed.

The nature and impact of patients' emotional wellbeing, aside from the reasons for their admission, is highlighted in the recent Government strategy '*Compassion in Practice: Nursing, Midwifery and Care Staff, Our Vision and Strategy*' (DH 2012b). Whilst all of the six fundamental values¹⁹ are of relevance, it is that of *compassion*²⁰ that does not appear to be reflected in the literature for those admitted to a PICU.

Whilst seclusion and restraint are used in the management of disturbed and aggressive behaviours within PICUs (Moran et al 2009), they remain

¹⁹The vision is underpinned by six fundamental values: care, compassion, competence, communication, courage and commitment (DH 2012b).

²⁰*Compassion* - is how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness, and is central to how people perceive their care (DH 2012b).

controversial. There are many arguments for and against the use of seclusion (Dix et al 2008). It is not within the scope of this project to debate the role of seclusion or restraint, however, within the two PICUs under scrutiny they remain an option in the care and management of severely disturbed and distressed patients. From their accounts all four participants experienced some form of restraint during this stay within PICU and two experienced at least one period of seclusion. The participants expressed a deep fear at the interventions they had received and also for other patients also.

Previous work undertaken regarding emotional responses to seclusion has focused on staff experiences, highlighting the distress among the nursing workforce that the use of seclusion initiates (Moran et al 2009). Nurses in Moran et al's (2009) work expressed anxiety, fear and guilt when describing restraint and seclusion. This project has identified that the patients too can experience anxiety and fear both for themselves and also in one participants' account when she witnessed the restraint of other patients.

The work undertaken by Meehan et al (2000) resonates with the findings in this project in that a key theme of patients' perceptions of seclusion was the emotional impact. Here the fear was specifically related to the direct experience of seclusion and being given medication by injections. Whilst Daisy and Diane referred to this, they also described fear in the context of a broader issue of *anticipated fear* and the unknown. They both described fear in respect of seeing acute care interventions with other patients, but also fear of the other patients and what they did not know about them. Research undertaken to date does not take these probable fears into account.

In the work of Moran et al (2009) nurses were described as suppressing unpleasant emotions in order to get through the restraint and seclusion processes. When combined, this suppression of emotions and the consequence failure to recognise the patients needs results in patients being left to deal with both their real and imagined fears about their care

without the support of nursing staff. In particular what 'treatment' and interventions they themselves may, in the coming days, experience.

The fear and anxiety continued for patients during their stay in the PICU and was resurrected for some patients when they observed other patients being taken to seclusion or restrained. This is echoed in previous work by Meehan et al (2000) and also evident in Daisy's account. The work of Meehan et al (2000) focussed solely on the experience of seclusion and not on the whole experience of receiving care in a PICU.

The depersonalisation of patients by nurses described in the work of Moran et al (2009) is one explanation for the experiences of Daisy and Diane who felt that they did not understand why they were being cared for in PICU. This heightened their detachment and consequent fear and anxiety at the care interventions

The findings of this study in light of existing literature suggest that when patients experience an episode of restrain or seclusion their emotional needs are not taken into account. Both during that time and also following the episode of intervention when the unit returns to its usual state. There is evidence that patients' experiences of seclusion contain a wide variety of emotions (Meehan et al 2000) and this study supports these findings.

However, through the accounts of the participants this study demonstrates the need to understand the connection that patients themselves make between the emotional experience of receiving care alongside the actual care itself. In particular the way staff care **about** the patients can influence how they care **for** the patient (DH 2007).

This study has highlighted that the emotional impact of being cared for in a the PICU continues after the acute episode has concluded. Whilst still in PICU and also following discharge to an open ward patients' emotions and needs regarding their experiences continue. This emotional impact of receiving intensive care does not appear to be taken into account by practitioners and patients appear to be left to understand their experiences alone and without the ability to verbalise or contextualise it.

Patients require an opportunity to explore their experiences of interventions both that they have received and witnessed others receiving in order to deal with the emotional impact this has and also to understand themselves and their identity in the context of their illness and experiences. This requires a specific approach to support them in addressing the emotional consequences of interventions and experiences whilst in the PICU.

In order to successfully engage in high quality care within the PICU increased regard should be given to compassion. To do so there needs to be a greater understanding of what this means in an intensive care environment. Compassion is one of the six NHS values²¹ (DH 2013). Compassion has many definitions; key to all definitions is the inclusion of demonstrative language. These include in particular; strengths, emotions, engagement, awareness, suffering (Firth-Cozens and Cornwell 2009).

However, findings of this study include that the act of delivering compassionate care in complex, difficult and emergency situations can be overlooked with adverse consequences for the patients.

Further findings within this study were *disorientation and confusion*. The phenomena of confusion and disorientation have been explored in relation to general acute hospital intensive care units. Here it is referred to as the ICU syndrome (Granberg et al 1999; Granberg et al 2001; Hartwick 2003). Additionally experiences described by patients in the ICU highlighted feelings of intense fear (Granberg et al 1999). Through this

²¹*NHS values* - The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS. The six values are: Working together for patients; Respect and dignity; Commitment to quality of care; Compassion; Improving lives; Everyone counts (DH 2013).

work and an earlier piece of work by the same research team it was identified that *'the caring relationship was perceived as providing an important degree of comfort'* (Granberg et al 1998, p. 294) and that this leads to a *'decrease in the tension caused by fear'* (Granberg et al 1999, p. 32).

The work also describes patients having an overwhelming feeling of fear and that they felt they were engaged in a *'fight for survival'* (Granberg et al 1999, p. 25). Within mental health literature no references to disorientation and confusion can be located that relates to an acute and intensive period of care.

Participant spoke about a fight and described a highly expressive and emotive time, it echoed the *'fight for survival'* described by Granberg et al (1999, p. 25). Whilst within this project there is the back drop of acute mental health issues and distress, the similarities to the ICU syndrome described by Eisendrath (1982) and referred to in the paper by Granberg et al (1999) are noteworthy. By contrast though, some participants described a positive relationship with the staff during the time they spent in the PICU; however, equally they expressed deep fear and anxiety. The findings from this project identifies that the work by Granberg et al (1999) and their perspectives regarding the *'caring relationship'* do not appear to translate to psychiatric intensive care.

This project has also found that the context of the interventions provided in psychiatric intensive care, notwithstanding a positive relationship with staff, leaves patients feeling fearful and afraid. The emotional responses patients have regarding the care received during the time they spent on the PICU continues once they have returned to the open ward.

This demonstrates that a positive relationship between staff and patients is not sufficient on its own to ensure patients feel safe. Through the very nature of the use of seclusion and restraint, the positive relationship and social, engaging aspects to the staff intervention is called into conflict when they are also those who must carry out the high level of distressing interventions. There is a need for clinical services and key staff groups to

develop a deeper level of engagement with patients in order to appreciate and assist patients in dealing with the fears and vulnerabilities they experience.

Recreational and therapeutic activities.

A view expressed repeatedly by patients is that acute mental health wards are boring with nothing to do (Ford et al 1998; SCMH 1998; Standing Nursing and Midwifery Advisory Committee 1999; Quirk and Lelliott 2001; MIND 2004; 'Rethink' 2004; Garcia et al 2005). Particularly 'Rethink' identified that there was a:

'Lack of 'something to do,' especially activity that is useful and meaningful to recovery. This is a recurring theme that has been described as a sort of 'suspended animation.'

('Rethink' 2004, p.16)

There is additional specific evidence of this from a number of sources. For example, during the Mental Health Act Commissioners' (MHAC) 'one day survey of adult acute psychiatric inpatient wards in England and Wales' it was noted that on 26% of wards there was no interaction with patients occurring by nursing staff (Ford et al 1998). Over 10 years later Radcliffe and Smith (2007) reflected on the fact that The Sainsbury Centre for Mental Health had also raised concerns regarding the absence of therapeutic activities in their report Acute Problems (SCMH 1998). Here it was identified that 40% of patients did not take part in any social or recreational activity during their stay and that patients were routinely dissatisfied with the activities they could undertake (SCMH 1998).

The impact of the absence of activities was also identified in Department of Health guidance (DH 2002a) with reference made to the effect boredom can have on inpatient wards:

'Boredom makes people worse – more ill, situations escalate in mental health units like they do in the taxi ranks.'

(DH 2002, p.21)

This is supported by a number of authors where the connection to an absence of activities and an increase aggression and violence. (Healthcare Commission 2007; Hamrin et al. 2009; Janner et al 2012). In spite of this considerable work has been undertaken to attempt to address the issues in providing activities. There is evidence of the benefits that an increase in activities, particularly with regard to lower levels of stress, aggression and patient satisfaction (Wildgoose et al 2005; SCMH 2006; Janner 2009; Armitage 2012). There remains a challenge with regard to what constitutes therapeutic engagement and this was evident within the findings of this project.

From the observations it was noted that there were a number of activities and engagement ongoing. In spite of this the respondents, whilst acknowledging that they had engaged in activities, referred in their accounts to a lack of activities and feeling bored. One explanation for this may be that the activities provided were not helpful or meaningful for the patient at that time. In a narrative provided by patient Janey Antoniou (2007 p. 33) she describes:

'There are two sorts of 'boring' on the ward. One is caused by having lots of hours to fill and not having the things one usually has to fill them up with because one is not at home. The other is a side effect, or a series of side effects from the medication(s). It is possible to be bored on the ward even when there are activities planned every hour, and not to be bored when doing nothing.'

(Hardcastle 2007)

This suggests that boredom is more complex than is thought, as there is an internal as well as an external component to boredom (Newell et al 2011). Additionally feelings of boredom appear to be inconsistent with the level of activities taking place and that it is the quality of relationships that matter to patients (Radcliffe and Smith 2007). Equally a small number of highly significant interactions may be more important than the time spent interacting (Radcliffe and Smith 2007). The interpretation of the

interaction and how patients interpret their experience is connected to their feelings of boredom (Conrad 1999). An individual will remain unstimulated if the activity or engagement has no meaning for them (Mikulas and Vodanovich 1993; Barbalet 1999).

Through the participants accounts within this project it was clear that meaningful engagement continued to be significant to them during the acute and intensive phase of their care. An additional perspective was also identified, being bored allowed time to think and also watch interventions with other patients. This contributed to the anticipated fear identified in the previous section. The findings of this study identified that patients are fearful about what may happen to them, but spend their time watching intensive interventions, restraint and seclusion happening to others whilst they themselves have little to engage their time. This, however, is cloaked in a veneer of low level activities and engagement between patients that masks the real activities of managing distressed and disturbed behaviour.

This project has shown that the complex correlation between the level and type of activities and engagements against the levels of boredom reported within acute admission wards remains consistent in PICUs. Given the nature of the environment and expected reasons for admission, the type and manner of engagement and activities are required to differ.

I would conclude that whilst a number of different activities and engagements are appropriate, they fall into two main distinct but potentially overlapping types:

1. That which patients, during a time of acute distress and disturbance, identify as being important and particular to them aside of the nature of their illness.
2. A higher level of activities that seeks to eliminate the requirement for or to minimise the impact and effect of intensive interventions such as restraint and seclusion.

5.2.2 Identity

Social identity as formulated by Tajfel and Turner (1979), is concerned with how we identify ourselves in relation to others according to what we have in common (for example, Katz et al 2002; Ellemers et al 2002). Particularly Tajfel describes social identity as;

'Social identity is that part of an individual's self-concept which derives from his knowledge of his membership in a social group together with the value and emotional significance attached to that group membership'.

(Tajfel 1981, p. 258)

Previous work has explored the experiences of patients through their mental illness and the impact this has upon their lives and their identity. This has been referred to and described in detail as a journey through mental ill health to understand their experiences and the development of a new identity (Foster 2007). This is separate and in addition to their experiences of the symptoms of mental illness and is about the emotional aspects that having a mental illness brings. Additionally it has been identified that those with a psychotic illness have had too little attention paid to their subjective experiences; this includes the acute emotional disturbances that accompany a psychotic episode (Sayre 2000). The journey described by Foster (2007) outlines how a person's social identity influences and is in turn influenced by a mental illness.

Hatfield and Lefley (1993) identified that some of the behaviours seen in psychiatric illness, such as anger and withdrawal, are not symptoms of the illness itself but attempts to cope with the stressful situation in which people find themselves. This phenomenon may explain some of the experiences expressed by the participants in this study, for example, being isolated in their bedroom and expressed frustration and anger at the boundaries imposed and being treated like a child. Sayre (2000) identifies this as patients spending time defending themselves against threats to their identity and self-esteem; this in turn leaves them less receptive to therapeutic efforts (Sayre 2000).

Individuals alter the degree to which they identify with a group depending upon the salience or prominence of that group at a given time (Tajfel 1981). Jackson et al; (2009, p168) also identify that this may also occur when the 'context' of a group changes and that this is significant when considering the change for a mental health patient from community care to an inpatient setting. The findings from this project take this a further step and have shown that just as the context changes from a community to an inpatient setting, it changes further again from an open ward to a closed PICU. Here there is a very specific set of circumstances and the *value and emotional significance attached to that group membership* (Tajfel 1981, p, 258) changes. Jackson et al (2009) identify that acceptance of the inpatient group membership may take some time and may at first be difficult to come to terms with. Some inpatients attempt to resist the new identity but acknowledge the necessity of joining the group given the context of being in hospital.

This project has identified that patients recognised the *necessity* to join or identify with a new group but found this difficult. This difficulty was due to a number of reasons, the length of stay being significantly shorter and the numbers of patients requiring intensive care are significantly less, means that this is a group with a smaller and more restricted membership. Patients questioned why they were in the PICU and particularly interrogated their current experiences against their previous life roles. There was a difference in patient experiences; some had a greater identity with other patients and for others a greater degree of analysis and caution was identified. Even where caution was expressed there was a sense of camaraderie. One explanation could be that despite some wariness of each other, they all were singular in their experiences of receiving high level interventions from the staff group.

The patients interviewed had all experienced previous admissions to the inpatient wards; however, admission to the PICU was new for them. This

had a profound effect on how they viewed themselves in the context of their experiences and their identity as a PICU patient.

The studies to date explore the concept of identity and the patient's journey through the whole of their experiences of mental illness (for example, Sayre 2000; Hall and Cheston 2002; Jackson et al 2009). This project has shown that specific elements of the whole journey are experienced within a PICU. For example, the specific 'micro journey' patients experience by admission to the PICU is a condensed version of the whole journey.

In addition this project identifies that patients identify with being a patient in the PICU and that there is an emotional conflict with the restrictive nature of the environment, which is not universally liked by the patients, and the smaller more personal nature of care that provides them with a greater sense of identity.

5.2.3 Interaction with others

The concept and nature of interaction between patients with each other and also the staff on the wards, has long been recognised as an area of significant influence in a patient's experience of inpatient care (for example, Ford et al 1998; SCMH 1998; DH 2002a; Bowles and Howard 2003; Johansson and Eklund 2003; Simpson et al 2005; Bowers et al 2009; Sharac et al 2010). Little research has been conducted within the field of intensive care regarding staff interaction with patients and the impact this has had, therefore this discussion will be framed by literature from either side of PICUs. That is, work carried out within open mental health wards and findings from work undertaken within forensic mental health wards.

A number of studies draw a particular distinction between therapeutic engagement and activities and a more general social interaction (for example DH 2002a; SCMH 2006; Janner 2009). Equally a literature review of patient activities undertaken identified a comprehensive list of reported

activities that included both therapeutic and social, recreational activities (Sharac et al 2010).

Whilst the idea and definition of therapy, engagement and activities can be discussed and interpreted extensively, for the purpose of this project and discussion it will be taken that the interaction referred to is that of social and informal interaction.

Despite social interaction, social engagement and informal task groups being identified within the literature review, greater regard is given for the formal therapeutic interactions and the identified therapeutic benefits of informal and social interaction is not considered. The findings conclude that staff spend 50% of their time with patients and that 4-20% is delivering therapy (Sharac et al 2010). Despite this, the review does not identify the benefits arising from the general social interaction. Equally it identifies that staff-patient ratio has an impact on the time spent with patients and that *'The findings that staff spend relatively little time in direct contact with patients and that patients spend little time with staff do not go hand-in-hand'* (Sharac et al 2010, p. 915). This is taken to imply that relatively low levels of staff on acute wards results in only a few patients reporting that they have spent time with staff. Equally this review highlighted that although up to 50% of staff time may be spent with patients, relatively little of it is spent on providing therapeutic interventions (Sharac et al 2010, p. 914).

Acute Problems (SCMH 1998) identified that research carried out in America found that the most effective acute wards provide high levels of staff and patient interaction (Ellsworth et al, 1979; Collins et al, 1985). The Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision (DH 2002a) identified that *'There needs to be a greater availability of appropriate space and facilities to stimulate therapeutic engagement, social interaction and recreation'* (DH 2002a, p. 22). Whilst this relates to adult mental health wards, the same guidance goes on to identify that PICUs should have *'very high levels of one to one staff to*

patient interaction by nursing, psychology, occupational therapy, social work, pharmacy, medical staff (DH 2002a, p. 25).

Similarly the Search for Acute Solutions identified that following a project aimed at developing therapeutic dining patient feedback included:

*'It's more normal, I don't feel we are being watched over.'
'Able to talk about normal things as well as issues about my illness.'*

(SCMH 2006)

Work to support staff in engaging with patients on mental health wards promote the simplicity of a 'normal' conversation (Janner 2009). This is further identified as doing what people do every day - talk to each other (Hand 2011).

Staff within this project employed the technique of a normal conversation; it was recognised by patients and they indicated a preference for this normal, everyday conversation. This was particularly identified by one participant who stated it was *'easier on all of us'*. This is supported by the observations I made on the two PICUs.

This, however, is in conflict with the conclusions drawn earlier in this chapter regarding the need to contextualise the emotional experiences felt by patients and the need for therapeutic conversations. It further serves to underline the conflicting experiences patient have during the time they spend in the PICU.

Patients reported that staff were 'fantastic' and they had positive relationships with everyone. It is difficult to conclude that against the backdrop of the expressed fear and anxiety regarding their time in the PICU that patients really felt that everyone could be friends, therefore I am left to speculate what the reason behind this is. One explanation is my role. Patients knew I worked for the Trust and that I occupied a senior position, therefore I wonder to what extent this influenced their responses to me

regarding the staff, or was it that the timing of my interview influenced their response. If I had carried out the interview or a further one following discharge, would they have felt able or more emotionally secure to provide a different account of their experience?

Patients are also identified as a source of support for each other. Work undertaken to examine the experience of being an inpatient on a mental health ward found that patients were recognised as providing peer support to each other (Wood and Pistrang 2004; Bouchard and Gros 2010; Repper and Carter 2011). Peer support is offering and receiving help between people in similar situations based on shared experience and understanding for mutual benefit, respect and empowerment (Repper 2013; Walker and Bryant 2013). Equally, peer support is also identified as a natural '*informal supportive camaraderie*' (Ockwell 2012) and support from '*similar others*' (e.g. Borkman 1999; Faulkner and Layzell 2001). That support from '*similar others*' was found to be more beneficial than what was provided by staff (Thomas et al 2002; Shattell et al 2008). Thomas et al (2002, p. 104) also referred to this as '*peer-administered therapy*' and identified that it was considered to be the most beneficial aspect of their hospitalization. Wood and Pistrang (2004) support this and identify the sense of being understood by another person in the same situation seemed highly valued by patients.

There is a growing body of work that is exploring in detail the role of peer support workers within mental health services. A recent feasibility study concluded that the development of peer support would be a way to supporting self management for people with long term [mental health] conditions (McLean et al 2012). Peer support workers may provide different types and dimensions of peer support (Repper 2013). The different types of peer support include:

- Informal, naturally occurring support.
- Peers participating in peer-run programmes.

- The employment for people with lived experience within statutory services.

(Repper 2013).

Recent work carried out to explore the role of naturally occurring peer support in acute mental health wards identified that *'peers are a source of diverse and unique support and that peers contribute to improved mental health outcomes and quality of life'* (Bouchard and Gros 2010, p. 598). Bouchard and Gros (2010) also identify the circumstance when peer support may be present. They describe group dynamics as being significant. They particularly related this to the creation of friendships and the identification of *'little groups'* (Bouchard and Gros 2010, p. 594).

Repper (2013) has brought together the collective learning from a number of other publications and examines the basic concepts and principles underlying the practice of peer support workers in mental health services. Recent work describes the role of peer support in detail (Davidson 2012). Here three aspects that appear to be unique or particularly well suited to peer support staff are described (Davidson 2012). These are:

- The instillation of hope and self-disclosure and demonstrating the possibility of being able to take control of their illness.
- Being a role-model and how to self-care ones illness.
- The nature of the relationship between the peer supporter and the patient.

Within this project the concept of sharing a social life and the provision of emotional support were both evident. This was evident throughout the social engagement identified during the periods of observations and expressed through all three participants' accounts. Participants described the social nature of chatting in the sitting room and male bonding activities, all identified the significance of this to them. It was also commented that it was easier to talk to *'people who knew what you were going through'*.

This project has identified that whilst patients reported normal everyday conversation from staff; they sought out their own informal peer support and found this to be beneficial. This differed from patient to patient and was influenced by their previous experiences.

The growth of a formal structure of peer support workers is a developing area within mental health. This includes the consideration of peer support roles in generic inpatient services. Following the experiences of patients highlighted within this project it is identified that there is potential for formal peer support workers within the PICU. Equally how these roles are developed could present an opportunity to take into account other findings from this project.

5.2.4 Atmosphere

Attention to the nature and role of the ward atmosphere of mental health settings has been present for many years; however, the ward atmosphere still remains a concept that is difficult to define (Duxbury et al 2006), grasp and to investigate (Brunt and Rask 2007). It has been identified that the ward atmosphere reflects the milieu in which care takes place (Tuveesson et al 2011).

In 1953 the World Health Organization (WHO) emphasised the importance of the atmosphere of a mental health hospital, identifying it as:

'The most important single factor in the efficacy of the treatment given in a mental hospital appears to the Committee to be an intangible element which can only be described as its atmosphere, and in attempting to describe some of the influences which go to the creation of this atmosphere, it must be said at the outset that the more the psychiatric hospital imitates the general hospital as it at present exists, the less successful it will be in creating the atmosphere it needs'.

(World Health Organization 1953; Cited in Haigh 2002).

Ward atmosphere encompasses the psychological, social and physical climate of the psychiatric ward and is commonly also referred to as the ward milieu (Duxbury et al 2006, p. 279). Equally Moos (1989, 1996) identified that it is the interaction of a number of elements, including policies and practices, the functioning of the patient and the social climate of the unit that create the ward atmosphere.

Whilst there are a number of differing definitions and discussions regarding the relationship between ward atmosphere and milieu, for the purpose of this discussion ward atmosphere will be used to encompass all definitions.

In 1989 Peplau acknowledged that '*an atmosphere conducive to recovery*' was a common feature of early psychiatric nursing literature (Brunt and Rask 2007, p.640). The importance of the ward atmosphere has never really disappeared, a survey of the quality of care in acute psychiatric wards carried out by The Sainsbury Centre for Mental Health (1998) made a recommendation that despite a ward having been recognised as having both destructive and therapeutic powers (Alden 1978), the hospital environment must be designed to deliver a relaxed and secure atmosphere and that the atmosphere should be conducive to calmness (SCMH 1998).

Individual patient factors such as self concept and cognitive ability appear to influence the perception of ward atmosphere (Thibeault et al 2010). In addition not all patients perceive ward atmosphere in the same way (Thibeault et al 2010). The quality of relationships between patients and staff is also a key factor in establishing good relationships and a helping alliance (Brunt and Rask 2007).

By contrast, conclusions from one research project carried out within forensic services identified that patients are not significant contributors to the ward atmosphere (Brunt and Rask 2007). Equally an ethnography of a locked inpatient mental health unit revealed that control overshadowed the health care environment (Johansson et al 2006, p. 247) and consequently the ward atmosphere.

The two PICUs included within this project both differed in terms of atmosphere. PICU D was the one observed to be most calm and quiet; in spite of this, it is the participants from PICU D who expressed the most anxiety, and watchfulness regarding the other patients. This suggests that the ward atmosphere or milieu has a deeper level of interpretation and what may appear as calm and quiet may hold the most apprehension for patients. In addition to factors outlined by Moos (1989, 1996) this study would add a further dimension that of the changeable nature of patients in a PICU. This also has an impact on the ward atmosphere, in particular the admission and discharge of patients. This particularly reflects the thoughts of the Trust Service User and Carer Research Group at an early stage in this project. Here they identified that the changing nature of the ward population impacts on how patients feel. This project has found that this can have both positive and negative consequences, affect the ability of patients to interact with each other and impact on how safe they feel.

Patient satisfaction is a desirable outcome of the health care environment, though milieu is seen as much more than a predictor of satisfaction and central to the patient's experience of care (Johansson et al 2006). The connection between atmosphere and outcomes of treatment appeared to be indirect but there is a connection between ward atmosphere and patient satisfaction (Jørgensen et al 2009). Here a relationship between higher staffing levels and higher levels of satisfaction was identified. Equally, wards with higher levels of symptoms were also identified as having an impact on the ward atmosphere and had lower level of satisfaction (Jørgensen et al 2009). The findings from this project would suggest that a connection between patient satisfaction and ward atmosphere is more complex. Both PICUs have equally high levels of staff and also patients who are distressed and potentially disturbed. Whilst participants within both expressed satisfaction with their care, the PICU where there were the highest level of symptoms was also where less anxiety and fear and consequently less dissatisfaction was apparent in the accounts of the participants.

The relationships between patients and their caregivers are a key dimension of ward atmosphere (Thibeault et al 2010). Patients experience some aspects of the milieu to be healing and nurses actions can be both protective and supportive (Thibeault et al 2010) and I believe significant to the healing experience of the patients. In keeping with this viewpoint, ward atmosphere has been linked to the helping alliance and therapeutic role (Johansson and Eklund 2004). Patients continue to value, and benefit from therapeutic engagement with their nurses and see this as a legitimate health care need (Thibeault et al 2010). This was evident within this project both from the observation sessions where the ongoing engagement of patients with staff was identified and also through the interviews, where participants identified differing levels of a relationship with staff at different times of their admission to the PICU.

This project has demonstrated that the ward atmosphere is very much dependant on the ward community, staff and activities that are taking place, including the level of symptoms that are displayed by patients. A sentiment expressed in 1962 by Stanton (1962; Cited in Brunt and Rask 2007, p. 640) continues to stand firm, that is:

'There is no patient untreated by his environment'.

5.2.5 A collective picture

The four master themes, through their individual discussion, identify how each influences the experience of patients during the time they spend in the PICU. However, the true learning and opportunity to discover what it is like to be cared for in a PICU and therefore to positively guide and influence practice to enhance patients' experiences of the PICU, can be known by taking a collective view of the four issues. The four master themes and their respective super-ordinate themes are influenced by and in turn influence each other. This collective picture, shown in Figure 19, illustrates how the Master and Super-ordinate themes link together.

The findings and discussion identify that patients report the PICU as being frightening, with increased levels of anxiety and an absence of understanding about care and interventions they both receive and witness in others. They have difficulty contextualising these experiences in relation to themselves and their ongoing mental health issues. Patients are required to reconsider their own identity in terms of themselves, their illness and their families and friends. The impact of how the ward feels and the behaviours and nature of the other patients all serve to influence how safe they feel and also how they view themselves in light of being unwell and in receipt of psychiatric intensive care.

Journey of emotional self-fear, anxiety, disbelief, and frustration.

Relationship with others (family, staff, patients) on emotional self, - Boredom, hostility, gratitude.

Emotional response

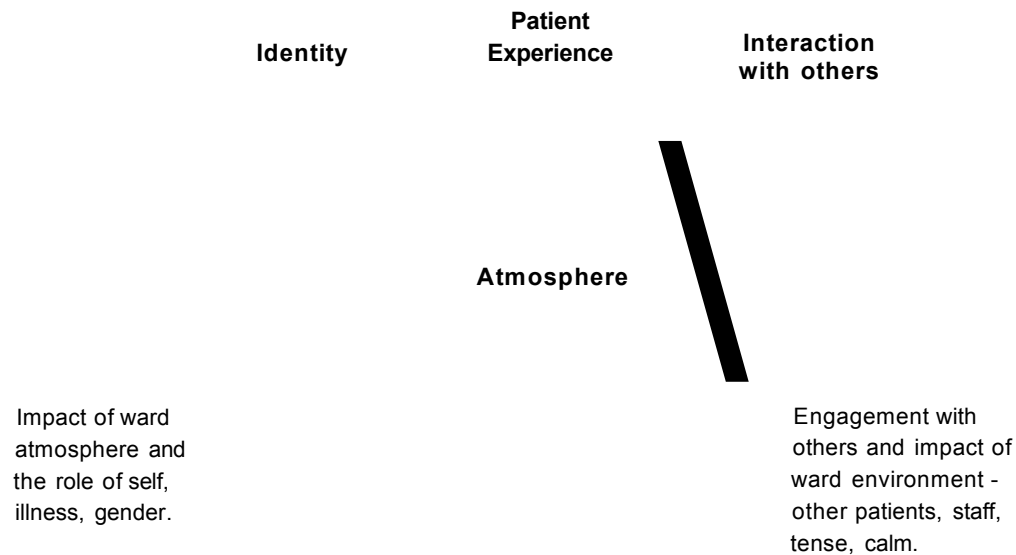


Figure 19: A collective Picture of the Master and Super-ordinate Themes

5.3 Significance of the study

A number of studies and literatures reviews have been carried out that seek to measure a person's experience of the quality of care received; but they do not enquire about the subjective experience of the patient. Rather they ask questions that services require/want answers to rather than hear the voice of the patient and understand the patient's frame of reference (Volante 2007). This project has illuminated the experiences of patients being cared for in the PICU.

As a consequence, this project has contributed to the existing literature and knowledge regarding the nature of psychiatric intensive care; however, it also identifies some specific new knowledge and findings that support care delivery and if addressed adequately could improve patient experience:

- Patients' experiences of psychiatric intensive care are frightening and prompt strong emotional responses.
- Some patients do not recall specific events, however, all recollect the distressing emotions attached to being cared for in the PICU.
- Patients have differing experiences of the relationships developed between themselves and also with staff during the time they spent in PICU.
- That a calm environment in PICU can evoke a feeling of fearful apprehension in patients.
- That witnessing other patients restraint leaves patients apprehensive about what will happen to them.
- Patients experience separation from their families, home and usual environments and this impacts on how they view themselves and their own identity.

Therefore the unique findings of this project contribute to the ongoing development of services that care for those with mental health issues in acute distress and who require intensive care.

5.4 Implications for Practice

Current research findings regarding care provided within PICUs focuses on the patient's admission, clinical procedures and treatments carried out.

The findings of this project illuminate patients' experiences from their own perspective on the care they receive; in light of this the implications for practice identify deeper elements of how care may be provided that supports a compassionate and caring approach. If practitioners are unable to understand what a patient experiences, then their approach may be structured in a more person centred style.

Whilst the methodological considerations described in the next section would urge caution regarding the transferability of the findings of this project across all PICUs, there are a number of implications for practice that may be identified. Recommendations for practice have been identified in Figure 20; these are also briefly explored around three areas:

1. The emotional wellbeing of patients distinct to their mental distress.
2. The nature and impact of sedation, seclusion and care interventions.
3. Role and function of the [changeable] ward community.

The emotional wellbeing of patients

1a. As part of the mental health assessment, staff should consider the emotional impact of being admitted to the PICU.

1b. From the mental health assessment carried out care plans written with each patient should take into account the emotional impact of being admitted to the PICU and the individual support that each patient requires.

2a. All patients within the PICU should be provided with de-briefing following any patient requiring restraint or seclusion.

2b. Following the de-brief staff should identify what specific needs or wishes each patient has.

The nature and impact of sedation, seclusion and care interventions

3. The PICU environment should support orientation to time, place and person in all areas including the seclusion suite, treatment room, bedrooms and other individual spaces.

Role and function of the ward community

4. As part of the generic assessment process staff should consider what impact the admission may have on the ward community and on individual patients, this should be acknowledged within the care planning process for each patient.

5. The Trust should explore the role of peer support workers within adult acute inpatient services.

Figure 20: Recommendations for practice

5.4.1 The emotional wellbeing of patients

This project has identified that patients experience a range of emotions both in response to and during their stay within a PICU. Whilst a number may be attributed to their mental health distress, it has been demonstrated that they also experience a range of usual emotions to a significant life event. For example the fear and disbelief that was expressed during the interviews may be in relation to their emotional distress, to the illness or circumstances that led to their admission in the first instance or that it is a natural emotional response when faced with something they do not understand. Therefore in order to support the development of practice in

relation to patient emotional wellbeing two recommendations for practice are made:

1.
 - a) As part of the mental health assessment, staff should consider the emotional impact of being admitted to the PICU.
 - b) From the mental health assessment carried out care plans written with each patient should take into account the emotional impact of being admitted to the PICU and the individual support that each patient requires.
2.
 - a) All patients within the PICU should be provided with de-briefing following any patient requiring restraint or seclusion.
 - b) Following the de-brief staff should identify what specific needs or wishes each patient has.

5.4.2 The nature and impact of sedation, seclusion and care interventions

During the interviews carried out for this project participants identified feelings of confusion and disorientation regarding the ward and themselves. This was related to their experience of seclusion and the use of medication. Particularly given the therapeutic environment and that it is located away from the main ward and hospital areas resulted in patients being cut off from usual community activity and losing track of time. Additionally, the nature of single rooms means that patients are afforded greater privacy and dignity; however, a consequence of this is that there are increased opportunities for them to be isolative both by design and as an unwanted outcome of their mental health. This in turn can lead to them becoming cut off from the ward community and become segregated and less accessible to care for. In response to these findings one recommendation is made to support ongoing care development:

3. The PICU environment should support orientation to time, place and person in all areas including the seclusion suite, treatment room, bedrooms and other individual spaces.

5.4.3 Role and function of the ward community

A significant element of the findings from this project was the impact of 'others' in patients' experiences. This included the role of families and partners, who were identified as providing significant support for them and this also contributed to their sense of identity and belonging during their time spent in the PICU. Also significant was the role that other patients and staff had on a person's experiences. Particularly this included the role of friendships and the impact of new, unknown, patients being admitted to the PICU. Therefore three recommendations are made that support the focus on patient relationships and the changing nature of the ward community:

4. As part of the generic assessment process staff should consider what impact the admission may have on the ward community and on individual patients, this should be acknowledged within the care planning process for each patient.
5. The Trust should explore the role of peer support workers within adult acute inpatient services.

5.4.4 Final meeting with the Trust Service User and Carer Research Group

The final meeting with the group took place following the analysis and as the discussion chapter was being assembled. The timing of this was significant on two main accounts. Firstly, the group were able to continue their role as a 'critical friend' in terms of the analysis and discussion and secondly they were able to provide their reflections on the process and outcomes and also to ensure that the conclusions I had generated would have real benefits for patients.

The main points and considerations the group had in light of the findings and discussion were:

- The group felt that the findings, discussion and in particular the significance of the study and implications for practice were meaningful to them. The findings had a resonance with their experiences and the recommendations for practice, they felt, could support real change for patients.
- Whilst the issue of stigma did not arise through the participants accounts, the Trust Service User and Carer Research Group felt that this was a significant issue. Given that the project had focussed on a person's experiences whilst they were still an inpatient it was suggested that issues regarding stigma may not emerge until after a patient was discharged. It was therefore proposed by the group that any future research should also seek patient views once they had been discharged. This is reflected in section 5.7.
- With regard to the master theme I identified as 'symptom reduction'. The group discussed the concept of 'recovery'²² in relation to symptom reduction. Within mental health recovery is a broad topic and it was felt that it was not within the scope of this project; however, the notion of a patient improving in their symptoms, experiences and mental health was significant. It was suggested by the group that this master theme could also be referred to as 'recovering'.

The final meeting with the group also enabled their views on the process of involvement in this project to be shared.

They felt their involvement had been significant and that they had been able to influence the project in a meaningful way, rather than findings being presented to them at the conclusion of a project simply to be signed off.

²²The concept of recovery is about a person staying in control of their life despite experiencing a mental health problem. There is no single definition of the concept of recovery for people with mental health problems, but the guiding principle is hope – the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. Recovery is often referred to as a process, outlook, vision, and conceptual framework or guiding principle (Mental Health Foundation 2013).

Equally they were able to share that inclusion in such work also supports their own mental health and wellbeing.

5.5 Methodological Considerations

5.5.1 Strengths and limitations to the study

A key strength of IPA particular to this study is that it enables researchers to understand healthcare and illness from the patient's perspective (Biggerstaff and Thompson 2008). Equally, the idiographic or individual nature of IPA described by Smith et al (2009) is also a strength in that the experiences of care by patients is very particular to each of them and IPA allows that individuality to be heard, allowing quality not quantity to be shown and to illuminate the complexity of human phenomena (Smith et al 2009).

There is a varied perspective on the strength of a *'fairly homogenous sample'* described by Smith et al (2009), in that the authors also identify that the effectiveness of IPA should be judged by the light it sheds on a broader context. This can be balanced against the view that this could be difficult if the sample is too specific or unique (Pringle et al 2011). Equally Willig (2001) identifies that IPA allows for creativity and freedom. This is identified as particularly important with unusual groups or situations, with groups that are difficult to reach (Pringle et al 2011) or where they may be *'outside the perceptual field of the healthcare practitioner'* (Biggerstaff and Thompson 2008, p.216). This is a further strength of this project, given that as identified earlier in this account, the nature of psychiatric intensive care means that the services and care provided and consequently the experiences of those within a PICU are out of sight.

Within this project the sample was a specific, unique group, selected purposively; nonetheless, I believe that the findings have the potential to shed light on a broader context as the very nature of PICUs and those who receive care are a very specific group of patients. Therefore whilst the findings are not broadly generalisable, they do demonstrate a theoretical transferability (Smith et al 2009). Equally that the sample size in this

project maintained the preferred size identified by Smith et al (2009) they also provide commonalities across accounts and an 'analytic commentary' (Reid et al 2005, p.23) that I believe leads to useful insights into experiences within a PICU.

There were three main identified limitations to this study.

Firstly, the sample selected. Whilst this was a purposive sample, there was no requirement through the project to understand the patient's diagnosis, background and treatment plan. The patients observed were a mixture of men and women of varying ages; however, those interviewed were mainly women and all were mainly between 20 and 40, resulting in a relatively homogenous sample. It could be contended that this is not representative of the potential patient group for a PICU. I have endeavoured to counter this by attempting to ensure that the accounts and discussion is sufficiently rich and transparent to *'enable readers to evaluate its transferability to persons in contexts which are more or less, similar'* (Smith et al 2009, p.51).

Secondly, the relationship between the observations sessions and the interviews carried out added additional complexity to the project. There were added benefits to the findings of the project in terms of the fact that the exploration of the phenomenon was from multiple perspectives (Smith et al 2009). This also helped me develop a more detailed and comprehensive account of the phenomenon, or triangulation (Reid et al 2005) and support the 'credibility checks' identified by Elliot et al (1999).

However, there was a weakness in the timings and overlap between the two phases. Whilst I was aware that there would be a requirement for me to be attentive to the movement of patients between the PICU, the open ward and assessment of their capacity to consent to take part in the interview phase. I was unprepared for the complexity of this and the need to be omnipresent to capture the windows of movement between the wards. The positive relationship I had with the ward staff and their commitment to support me with this project ensured I had appropriate and

timely access to patients; I did 'lose' one patient through her discharging herself against medical advice before I could return to the ward to see her. This was due to balancing observations on the PICU, my day to day senior nurse role and the need to be on the open wards, all at the same time.

Thirdly, that I restricted the patients I could observe on the PICU to those who would return to the open ward was an unsatisfactory approach. There were a number of patients who were being transferred directly to secure provision and by nature of the project required to be excluded. This was a missed opportunity to observe their behaviours in PICU and the interaction between the whole community.

5.5.2 Quality

In order to critique the approach to quality with regard to this study I will return to the four principles proposed by Yardley (2000) outlined in Chapter 3:

From a reader's perspective *sensitivity to context* will have been an inherent part of producing a study and will therefore, in part, be judged indirectly (Smith et al 2009). Consequently within this project, in order to demonstrate that sensitivity to the raw material of the patient accounts within the interviews has been preserved, verbatim extracts to support the arguments I made and to evidence my analysis have been used. Thus giving participants a voice in the project and allowing the reader to check my interpretations (Smith et al 2009). Smith et al (2009) also identified that sensitivity to context may be achieved by appropriate use of the literature to orient the findings and discussion. In light of the dearth of literature relating specifically to psychiatric intensive care, the discussion within this project endeavoured to achieve this through literature whereby parallels could be drawn to illuminate the as yet unexplored experiences of patients during the time they spend in the PICU.

Qualitative research is often criticised for lacking scientific *rigour* (Mays and Pope 1995); however, an identified basic strategy to ensure rigour in qualitative research mirrors that in quantitative research is systematic and

detailed research design, data collection, interpretation and communication.

Yardley (2000) supports this and identifies that the completeness of the data collection and analysis, completeness of the interpretation and to triangulate the data all provide rigour to the project. In IPA this can refer to the use of in-depth interviews, balanced probing interviews and thorough interpretative analysis (Smith et al 2009).

I have endeavoured to achieve this through utilising two of Creswell's (2007) strategies that are most relevant to this project:

- Prolonged engagement and persistent observation, through the time spent observing participants during their time in the PICUs.
- The rich, thick description from the interviews. Carried out as soon as possible following the patients discharge from the PICUs to ensure that valuable memories and experiences were not lost.

When considering adherence to Yardley's concept of *transparency and coherence* (Yardley 2000), Smith et al (2009) identify that there should be a single experiential domain for participants and that this should be attended to during the writing up of the project. This has been demonstrated through this project with the experience of being cared for in a PICU as the central domain that all participants were experiencing, indeed it is this that identified them purposively as a candidate for the project.

This project has attempted to construct a version of the reality of being cared for in a PICU and it endeavoured to create an account that is successful in communicating this in a meaningful way (Yardley 2000). Equally I sought to triangulate the findings in a way that was guided by those who had also experienced acute mental health care and not through relatives or health professionals or by 'deconstructing' the interviews which is seen as inappropriate in terms of maintaining *transparency and coherence* (Yardley 2000).

The true measure of the *Impact and importance* of this project will only be measured through the perspective and response of the mental health community, that is the reaction of patients, clinicians and leaders of services. Whilst through this account I have attempted to present a sensitive, thorough and plausible analysis (Yardley 2000), if the information I have set out does not resonate then the findings will have little influence on the development of practice. I believe through the coherent journey of this work it presents relevant findings to the psychiatric intensive care community.

5.6 Audit

Smith et al (2009) suggests that audit is a powerful way to consider the issues of validity in qualitative research. This is supported by Yin (1989) who suggests that one way of checking is to conduct the research and file the data in a way that means another person could follow the project through.

Through this project I have systematically followed a clear process from the initial notes for the project through the research proposal, journey of the project itself and the interview, transcripts and analysis. Equally the verbatim quotes used within the analysis can be traced back to the transcripts, through the recordings and back to the engagement on the open ward and the observations in the PICUs. Thus demonstrating that, hypothetically another person *could* check through the 'paper trail' (Smith et al 2009, p. 183).

5.7 Suggestions for future research

The body of literature on the experiences of patients receiving care in an intensive care unit is very limited. The findings from this project has demonstrated significant new findings regarding the experiences of those receiving psychiatric intensive care, particularly with regard to their emotional wellbeing, the nature and impact of some of the interventions

used within PICUs and the role and function of the ward community and interaction of patients.

However, these findings also suggest further work that could be undertaken in order to enlighten very specific aspects of care. In particular given a key emotional experienced is that of fear, the concept of *anticipated fear* and the therapeutic relationship between nurses and patients with regard to intensive interventions and the effect this has on patient's experiences of fear would benefit from further exploration.

Further areas of research suggested by this project would include further exploration of the specific nature of activities that provide therapeutic benefit for patients admitted to PICUs and how to ensure they *feel* engaged during their stay, in particular additional understanding of the concept of 'boredom' and 'engagement'.

Finally the research suggestions identified above would benefit from exploration of the whole PICU community, including staff and all patients; not just those who are to be transferred back to the open wards. Equally the entire patient pathway would be usefully explored, this could include interviews once a patient had been discharged and also allow for any issues regarding stigma to be explored.

5.8 Reflections on the study

Hindsight is a marvellous thing. At the end of this project I have a number of reflections. Firstly they centre around my professional role and impact on services. I occupy a senior role within the Trust and this meant that whilst I endeavoured to engage with staff and patients as a researcher, I was and could never shake off the fact that I occupied a significant position. Undoubtedly this impacted, that it gave me greater access to services than I would have ordinarily been afforded is relatively clear, but how it impacted on staff behaviour I can never really measure. I feel it helped that I had worked on the wards clinically, albeit a number of years ago; however, I feel I had some degree of clinical credibility than if I had only occupied my current role.

With regard to methodology, I feel that using IPA proved to be an excellent way to achieve the project aims and at the end of the project would not have changed that course. As is the case of using a new approach or technique, now I understand the complexities and approaches in IPA I would frame a number of aspects differently. Specifically I would include all patients in the observation phase, I would approach the patients on their discharge from the PICU; in addition, I would also seek to interview them an additional time to establish their ongoing recollection of their experiences. Equally I would allow a greater time frame to carry out the analysis, and allow opportunity to revisit the analysis more than once.

5.9 Dissemination

A key aim of this project was to illuminate patients' experiences of psychiatric intensive care; therefore in order to successfully achieve this aim the final piece is the appropriate dissemination of my findings. Particularly in how, through changes to how clinical staff organise care and communicate with patients, their experiences may be improved and enhanced.

The findings of this project identify a unique contribution to existing literature and this should be shared as it has some significant messages for patients, mental health professionals and health care policy development.

Through the course of this project I have shared my journey at key events including:

- Presentation at The 15th Annual National Association of Psychiatric Intensive Care Units (NAPICU) Conference 'Improving the Patient Experience', 9th – 10th September 2010, University of York, England.
- Poster presentation at the 2011 RCN Mental Health Research Conference.

- Poster presentation at The RCN 2013 Annual International Nursing Research Conference 20th – 22nd March 2013, Belfast, Northern Ireland.

Now complete my findings will be shared with appropriate groups within the Trust including the ward teams from the adult mental health wards and PICUs. I also intend to disseminate my project journey and findings in the following ways:

- Publish articles in academic journals.
- Write for professional nursing publications.
- Seek to join and contribute to regional, national networks and conferences.

5.10 Summary

This discussion chapter has, following the detailed analysis of chapter four, highlighted key considerations for practice as a consequence of the research undertaken in this project. This has been done in a selective and not exhaustive manner, using that which is particularly resonant to this study and its parameters.

Specifically the four key areas are the emotional response to being cared for in the PICUs, patients identity, patients interaction with others and the unit atmosphere.

This chapter outlines that the findings in this study contribute to existing literature and knowledge regarding the nature of psychiatric intensive care; it also identifies some specific unique new findings that support care delivery and contribute to the ongoing development of services that care for those with mental health issues in acute distress and who require intensive care.

This chapter also identifies a number of implications for practice and these were explored around three areas, the emotional wellbeing of patients

distinct to their mental distress, the nature and impact of sedation, seclusion and care interventions and the role and function of the [changeable] ward community. Six recommendations were made for the ongoing development of practice.

The strengths and limitations to the study were explored and outlined, identifying three main limitations to the study. Using the four quality principles proposed by Yardley (2000) the chapter also critiqued the approach to quality within this project. Following the review of the main findings, implications for practice and limitations of the study suggestions for future research were identified. Finally, personal reflections on the study were outlined and dissemination of the findings that have already been undertaken and those proposed for the future were detailed.

5.11 Conclusion

This project sought to examine:

'By their own account, what are patients' experiences of their care during their time spent in a Psychiatric Intensive Care Unit?'

This was through the illumination of patients' experiences of psychiatric intensive care and the exploration the meaning that patients ascribe to their experiences of psychiatric intensive care. Collectively this was in order to initiate an understanding of what it is like to be cared for in a PICU.

Through interpretative phenomenological analysis (IPA) an in-depth examination of the experiences of patients was conducted. This enabled significant and particular experiences of patients and the meaning that they ascribe to that experience to be examined.

Three key areas were identified that illuminate patient experience. These were, patients experiences of psychiatric intensive care are frightening and prompt strong emotional responses, patients value the relationships developed between them and also with staff during the time they spent in the PICU and during the time spent in the PICU patients experience separation from their families, home and usual environments.

This has enabled a greater understanding of how patients feel about their care that is provided within a PICU, and has supported the generation of recommendations for improving practice and care delivery in a way to enhance the experience for patients. The recommendations are focussed on three areas, the emotional wellbeing of patients distinct to their mental distress, the nature and impact of sedation, seclusion and care interventions and the role and function of the [changeable] ward community.

Collectively, the journey of this report, the endeavours to hear the voice of those receiving intensive psychiatric care and the recommendations for practice that arise from the findings, support a key sentiment expressed following the publication of the Francis Inquiry (2013):

'The Francis report is a powerful reminder that we need a renewed focus on hearing and understanding what patients are saying'.

Ruth Thorlby, Senior Fellow, Nuffield Trust.

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Consultee Information Sheet:

The accounts of patients receiving Psychiatric Intensive Care

I would like to invite you to consider your relative taking part in our research study. This is looking at patient experiences of their care on either ward or ward.

We feel your relative is unable to decide for himself/herself whether to participate in this research. To help decide if he/she should join the study, we would like to ask your opinion whether or not they would want to be involved.

You are being approached as the consultee for your relative under guidance outlined in the Mental Capacity Act. It identifies that the person we consult must be involved in the patient's care, interested in their welfare and must be willing to help.

As you have been consulted as their nearest relative during the time they were brought into hospital, ward or ward we feel that you are in the best position to be able to advise us on their wishes.

We ask you to consider what you know of their wishes and feelings, and to consider their interests. Please let us know of any advance decisions they may have made about participating in research. These should take precedence.

If you decide your relative would have no objection to taking part we will ask you to read and sign the consultee declaration that you have been given along with this information leaflet. We will then give you a copy to keep.

We will keep you fully informed during the study so you can let us know if you have any concerns or you think your relative should be withdrawn. If you decide that your relative would not wish to take part it will not affect the standard of care they receive in any way.

If you are unsure about taking the role of consultee you may seek independent advice. We will understand if you do not want to take on this responsibility. The following information is the same that would have and will in the next stage of this research be, provided to your relative.

One of ward nurses or the researcher will go through this information sheet with you and answer any questions you have - This should take about 15 minutes.

What is the purpose of the study?

Receiving intensive care on either [REDACTED] ward or on [REDACTED] ward can be a difficult and distressing time and there is very little evidence and understanding about what it is like to experience this intensive care, what is important to patients and how they feel about the time they spend being cared for in such an intensive way.

This study aims to gain a greater understanding from patients by observing them during their time on [REDACTED] ward or [REDACTED] ward and then spending time discussing their experiences with them. The study is being undertaken as part of a doctoral research degree by Deborah Wildgoose, based at Sheffield Hallam University and [REDACTED] NHS Foundation Trust.

Why have they been invited?

We are inviting all patients who spend some time being cared for on either [REDACTED] ward or [REDACTED] ward during June and August 2010 to take part in this study.

Do they have to take part?

Participation is entirely your decision – you do not have to agree to them taking part if you do not want to. If you decide **not** to agree to them taking part, then this decision will not affect the care they receive in any way. If you do decide for them to take part, you will be asked to sign a consultee declaration form which you will receive a copy of. You will still be able to change your mind and take away your agreement at any time without giving a reason, and this will not affect the care that they receive in any way.

What will happen to them if they take part?

If you decide to allow your relative to take part in the project, they will be observed during their day to day care whilst on either [REDACTED] ward or [REDACTED] ward. Notes will be made of these observations. Once your relative has been transferred back onto one of the open wards they will be approached to see if they would agree to the observations that have been made on their care whilst on [REDACTED] ward or [REDACTED] ward being discussed with them in the form of a semi-structured interview.

This means that there will be some questions but they will be free to discuss aspects of their care that are most important to them. This discussion/interview will be either audio recorded or notes made which ever they feel most comfortable with. The recording or notes will be typed up. The discussion/interview will take approximately 1 hour.

What will they have to do?

All they have to do is to take part in the discussion/interview. They do not have to answer or discuss anything that they do not want to and they can ask any further questions at anytime.

What are the possible disadvantages and risks of taking part?

It is possible that they might find it upsetting to talk about their time on intensive care. If they do then they can stop the interview at any time. If they wish the interviewer can put them in touch with their named nurse or care coordinator.

What are the possible benefits of taking part?

Talking through and discussing experiences that they have had might benefit them, although we cannot guarantee this. We also hope that this project will help us understand the experiences of patients cared for within intensive care ([REDACTED] ward and [REDACTED] ward) and help to improve the services we offer in the future.

Will their taking part in the study be kept private and confidential?

Yes, their name and details will not be used in any of the information collected or in any reports. All information gathered during this project will be coded to ensure that their name and details are not identifiable and it will be stored in a locked cupboard and any computer files used will be password protected.

The only people who will have access to the information gathered will be the researcher and relevant staff at the supporting University – Sheffield Hallam University. This will be my project supervisor and members of the research regulation authorities.

All information obtained will be kept securely for 3 years before being destroyed.

What will happen if I don't want them to carry on with the study?

You are free to decide to no longer allow your relative take part in the study at any time without giving a reason. Any information collected up to then will be held and you will be asked if that information can be used in the project, if you agree then it will be included, if you do not wish it to be used it will not be included in any of the project. This will not affect any care that they receive in any way.

What if there is a problem?

If you have a concern about any aspect of this study, you can speak to the researcher, Deborah Wildgoose on [REDACTED], who will do her best to answer your questions. Alternatively, you can speak to her project supervisor: Alex McClimens, who can be contacted on [REDACTED].

If you remain unhappy and wish to complain formally, you can do this through the Trust complaint process. Details can be obtained from any of the ward staff or by contacting either:

Trust complaints officer:

[REDACTED]

[REDACTED]

Patient Advice and Liaison Service (PALS)

[REDACTED]

Involvement of the General Practitioner/Family doctor (GP)

As their treatment and stay in hospital will not be affected by them taking part in this project their GP will not be informed.

What will happen to the results of the research study?

The information will be written up as a report and published for other health professionals to read. It will also be presented to other health professionals as part of a conference aimed at improving services offered to people with mental health needs.

Who is organising and funding the research?

This project is being funded jointly by [REDACTED] NHS Foundation Trust and the Yorkshire and Humber Strategic Health Authority and is being overseen by the Sheffield Hallam University.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. They are there to protect your relative's safety, rights, well-being and dignity. This study has been reviewed by the Bradford Research Ethics Committee.

You will be given a copy of this information sheet and, if you agree to your relative taking part in the study, you will be given a copy of your signed consultee declaration from for you to keep.

Further information and contact details

Should you wish to have further information about this project, or have any questions or worries please do not hesitate to approach your relative's named nurse or care coordinator or directly to Deborah Wildgoose (Researcher) on [REDACTED] or Alex McClimens (Project supervisor) on [REDACTED]

Thank you for taking time to read this information sheet.

CONSULTEE DECLARATION FORM

Study Number:

Patient Identification Number

Title of Project: **The accounts of patients receiving Psychiatric Intensive Care**

Name of Researcher: **Deborah Wildgoose**

Please initial
box

1.1 _____ have been consulted about
.....'s
Participation in this research project. I have had the opportunity to ask questions about the study and understand what is involved.

2. In my opinion he/she would have no objection to taking part in the above study.

3. I understand that relevant sections of his/her care record and data collected during the study may be looked at by responsible individuals from|

NHS Foundation Trust, where it is relevant to their taking part in this research.

Name of Consultee

Date

Signature

Relationship to participant

Name of Person
taking consent

Date

Signature

When completed: 1 for researcher site file; 2 for consultee; 3 to be kept in clinical records.

Patient Information Sheet:

The accounts of patients receiving Psychiatric Intensive Care

I would like to invite you to take part in our research study. This is looking at patient experiences of their care following being cared for on either [REDACTED] ward or [REDACTED] ward. Before you decidewhether you wish to take part or not, I would like to tell you more about the study.

One of ward nurses or the researcher will go through this information sheet with you and answer any questions you have – This should take about 15 minutes.

Talk to others about the study if you wish and feel free to ask if you would like any more information.

What is the purpose of the study?

Receiving intensive care on either [REDACTED] ward or on [REDACTED] ward can be a difficult and distressing time and there is very little evidence and understanding about what it is like to experience this intensive care, what is important to patients and how they feel about the time they spend being cared for in such an intensive way.

This study aims to gain a greater understanding from patients by observing them during their time on [REDACTED] ward or [REDACTED] ward and then spending time discussing their experiences with them. The study is being undertaken as part of a doctoral research degree by Deborah Wildgoose, based at Sheffield Hallam University and [REDACTED] NHS Foundation Trust.

Why have I been invited?

We are inviting all patients who have spent some time being cared for on either [REDACTED] ward or [REDACTED] ward during June and August 2010 to take part in this study.

Do I have to take part?

Participation is entirely your decision – you do not have to take part if you do not want to. If you decide **not** to take part, then this decision will not affect the care you receive in any way. If you do decide to take part, you will be asked to sign a consent form which you will receive a copy of. This means that you have agreed to take part and makes sure you understand what the project is about. You will still be able to change your mind and take away your agreement (consent) at any time without giving a reason, and this will not affect the care that you receive in any way.

If you would rather not take part in the interviews but don't mind the researchers including the observations made during your time on [REDACTED] ward or [REDACTED] ward then you can agree to this on the consent form.

What will happen to me if I take part?

If you decide to take part in the interviews, the observations that have been made on your care whilst on [REDACTED] ward or [REDACTED] ward will be discussed with you in the form of a semi-structured interview. This means that there will be some questions but you will be free to discuss aspects of your care that are most important to you. This discussion/interview will be either audio recorded or notes made whichever ever you feel most comfortable with. The recording or notes will be typed up. The discussion/interview will take approximately 1 hour.

What will I have to do?

All you have to do is to take part in the discussion/interview. You do not have to answer or discuss anything that you do not want to and you can ask any further questions at anytime.

What are the possible disadvantages and risks of taking part?

It is possible that you might find it upsetting to talk about your time on intensive care. If you do then you can stop the interview at any time. If you wish the interviewer can put you in touch with your named nurse or care coordinator.

What are the possible benefits of taking part?

Talking through and discussing experiences that you have had might benefit you, although we cannot guarantee this. We also hope that this project will help us understand the experiences of patients cared for within intensive care ([REDACTED] ward and [REDACTED] ward) and help to improve the services we offer in the future.

Will my taking part in the study be kept private and confidential?

Yes, your name and details will not be used in any of the information collected or in any reports. All information gathered during this project will be coded to ensure that your name and details are not identifiable and it will be stored in a locked cupboard and any computer files used will be password protected.

The only people who will have access to the information gathered will be the researcher and relevant staff at the supporting University – Sheffield Hallam University. This will be my project supervisor and members of the research regulation authorities.

All information obtained will be kept securely for 3 years before being destroyed.

What will happen if I don't want to carry on with the study?

You are free to decide to no longer take part in the study at any time without giving a reason. Any information collected up to then will be held and you will be asked if that information can be used in the project, if you agree then it will be included, if you do not wish it to be used it will not be included in any of the project. This will not affect any care that you receive in any way.

What if there is a problem?

If you have a concern about any aspect of this study, you can speak to the researcher, Deborah Wildgoose on [REDACTED], who will do her best to answer your questions. Alternatively, you can speak to her project supervisor: Alex McClimens, who can be contacted on [REDACTED]

If you remain unhappy and wish to complain formally, you can do this through the Trust complaint process. Details can be obtained from any of the ward staff or by contacting:

Trust complaints officer:

[REDACTED]

Or...

Patient Advice and Liaison Service (PALS)

[REDACTED]

Involvement of the General Practitioner/Family doctor (GP)

As your treatment and stay in hospital will not be affected by you taking part in this project your GP will not be informed.

What will happen to the results of the research study?

The information will be written up as a report and published for other health professionals to read. It will also be presented to other health professionals as part of a conference aimed at improving services offered to people with mental health needs.

Who is organising and funding the research?

This project is being funded jointly by [REDACTED] NHS Foundation Trust and the Yorkshire and Humber Strategic Health Authority and is being overseen by the SheffieldHallamUniversity.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. They are there to protect your safety, rights, well-being and dignity. This study has been reviewed by the Bradford Research Ethics Committee.

You will be given a copy of this information sheet and, if you agree to take part in the study, you will be given a copy of your signed consent form for you to keep.

Further information and contact details

Should you wish to have further information about this project, or have any questions or worries please do not hesitate to approach your named nurse or care coordinator or directly to Deborah Wildgoose (Researcher) on [REDACTED] or Alex McClimens (Project supervisor) on [REDACTED].

*Thank you for taking time to read this
information sheet.*

Observation Schedule – S and K

GENDER IMPACT

INTERACTION BETWEEN PATIENTS

RAPID CHANGING PATIENT GROUP – DYNAMICS

IMPACT OF DISCHARGES AND ADMISSIONS

RELATIONSHIPS WITH STAFF

OTHER SIGNIFICANT OBSERVATIONS

Semi-structured Interview Schedule

Venue: The interview will take place in an environment acceptable to the patient. This will be clarified with the patient and will be either on the ward in a private room or their bedroom, or off the ward in a venue that is acceptable to them and also their care team taking into account their needs, i.e. section 17 leave etc..

Time: The time of the interview will be checked with the patient and arranged at a time convenient to them taking into account visitors, care package and their wellbeing. Let the patient know how long it is expected to last (about 1 hour)

Consent: Prior to the interview commencing their consent will be re-established.

Taping/recording: Methods of recording or note taking will be discussed and the patients preference established. The interview will be conducted using their preferred method of recording - notes or recording.

Framework for the semi-structured interview:

The specific themes will be built up as part of the analysis work from the observations within PICU and discussion with the user/carer research group.

- Opening questions regarding their stay in PICU and on the open ward
- Reflect key themes (between 6 - 10) identified from analysis of observation work and through engagement with the user/carer research group by the use of open questions
- Offer opportunity to discuss each theme:
- Their understanding of the theme
- What it means to them
- Employ active listening skills to reflect/check and clarify what is being expressed.
- Go through each theme individually

At conclusion of interview check if there is anything else they would like to say or add.

Explain process of typing up/transcribing the notes and give them the opportunity to check the final notes, if necessary make the arrangements.

Thank them.

***for their time
involved in this project.***

being

NHS

National Research Ethics Service

Tel:
Fax:
Email:

20 May 2010

Mrs Deborah Wildgoose

Dear Mrs Wikigoose

Study Title: Qualitative Study of the accounts of service users receiving paediatric intensive care

REC reference number

Protocol number:

The Research Ethics Committee reviewed the above application at the meeting held on 18 May 2010. Thank you for attending to discuss the study.

Ethical opinion

When asked about observation noted you confirmed that you would not **identify patients in the research** notes rather **would use initials or codes**. **You would** then use the data **from the observations, and from the service user group** to identify themes. Interviews with participants would **then use** these themes rather than referring **to individual events**.

This Research Ethics Committee is an advisory committee to the West of Scotland Strategic Health Authority. The West of Scotland Strategic Health Authority is a public body established under the Health Service (Reorganisation) Act 2004. It is a member of the Scottish Health Service. For more information, please contact the Research Ethics Committee on 0141 276 2000. **F2Q**

Regarding the consent process, you explained that once back on Me admissions ward, and recovered, potential participants would be approached and asked to participate. If they agreed Men consent would be taken. If that participant then went on to withdraw consent this would be respected. If the patient's capacity decreased due to illness Men participation would be halted and they would be approached again once recovered.

The Committee asked if direct quotes were to be used Men specific consent for Mis should be obtained.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. I will write to you again as soon as one Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at non-NHS sites.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research (TR&D approval) should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

Other conditions BPB filed by the REC

1 If direct quotes were to be used then specific consent for this should be obtained. TMs should be submitted to the Committee for review as a substantial amendment.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	version	Date
covering Letter		07 April 2010
REC application		01 April 2010
Protocol	6	01 March 2010a
investigator CV	D W B d q o o s e	05 January 2010
Participant information Sheet: For service users	1	01 January 2010
Participant information Sheet: CtoRIMtse		01 March 2010
Participant consent Form: For service users	t	01 January 2010a
Participant consent Form: Declaration	f	01 March 2010
Referees or other scientific critique report		05 December 2009
Interview Schedules Topic notes		01 January 2010
investigator CV	1	12 January 2010

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of Compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document 'After ethical review - guidance for researchers' gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators

**Progress and safety reports
Notifying the end of the study**

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email

Please quote this number on all correspondence

~|

With the Committee's best wishes for the success of this project

Chairman

Email:

Enclosures:

List of names and professions of members who were present at the meeting and those who submitted written comments

'After ethical review - guidance for researchers'

Copy to:

*Academic Supervisor tikmtgomery House 32 Coffegiate
Crescent Coffegiate Campus Sheffield S10 2BP*

*Enterprise Centre Sheffield Hallam University Science
Park Unit 6, Howard' Street Sheffield S1 1WB*

01 March 2012

Mrs Deborah Wildgoose

Dear Mrs Wildgoose

Study title: Qualitative Study of the accounts of service users receiving Psychiatric Intensive care

REC reference:

Amendment number:

Amendment date: 12 January 2012

The above amendment was reviewed on 29 February 2012 by the Sub-Committee in correspondence

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting Documentation

Approved documents

The documents reviewed and approved at the meeting were

Document	Version	Date
Supervisor CV		
Academic Supervisor Declaration		06 January 2010
Investigator CV	Deborah Wildgoose	06 January 2010
Protocol	7	01 December 2011
Notice of Substantia Amendment (nan-CTIMPs)	1	12 January 2012
Covering Letter		18 February 2012

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet

R&D approval

All investigators and research collaborators in 'Tie NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK

IQff11302/34

Please quote this number **on** all correspondence

Yours sincerely

ff

Enclosures: *List of names and professions of members who took part in the review*

Copy to

NRES Committee Yorkshire & The Humber - Bradford

Attendance at Sub-Committee of the REC meeting on 29 February 2012

<i>Name</i>	<i>Capacity</i>
Professor of Biomedical Sciences	Expert
Clinics! Director Occupational Health	Expert

A Research Ethics Committee established by the Health Research Authority

Health **NHS**
Research

22 July 2013

Mrs Deborah Wildgoose

Dear Mrs Wildgoose

Study title: Qualitative Study of the accounts of service users receiving Psychiatric Intensive care

REC reference:

Protocol number: TV7W

Amendment number: Substantial amendment 2, Consent from service users

Amendment date: 24 May 2013

IRAS project ID:

The above amendment was reviewed by the Sub-Committee in correspondence

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Consent Form: Service User Consent Form	1	24 May 2013
Participant information Sheet; Service User Information Sheet	t	24 May 2013
Notice of Substantial Amendment (non-CTIMPs)	Substantial amendment 2. Consent from service users	24 May 2013
Covering Letter	delete	

A Resnncnti £:tnr.s Committcn established by thn Hnaltu Resflarh Authority

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members training days see details at <http://www.hra.nhs.uk/hra/training/>

Please quote this number on all correspondence

Yours sincerely

PP

Committee Member

E-mail

Enclosures.

List of names and professions of members who took part in the review

Copy to:

NRES Committee Yorkshire & The Humber - Bradford

Attendance at Sub-Committee of the REC meeting held via correspondence

<i>Name</i>	<i>Profession</i>	<i>Capacity</i>
	Head of Psychological Therapies	Expert
	Senior Lecturer	Expert

Service User Information Sheet:

The accounts of service users receiving Psychiatric Intensive Care

Following your consent to take part in the above research study in 2012 I would like to seek additional consent from you to use short extracts from your interview in the form of anonymous quotes in the study report. No one will be able to identify you from the report.

One of the community workers or myself will go through this information sheet with you and answer any questions you have – This should take about 10 minutes.

What is the study?

Last year in 2012 I approached you to seek your consent to take part in this study. As you did consent to this I then carried out an interview with you and recorded or wrote everything that you said down. This is now being used to write the research report.

As part of that report I would like to use anonymous quotes from your interview to illustrate what I have found during the research.

Do I have to take agree?

Agreement to using the quotes is entirely your decision – you do not have to agree if you do not want to. If you decide **not** to, then this decision will not affect the care you receive in any way. If you do decide to allow the quotes to be used, you will be asked to sign a consent form that you will receive a copy of.

What will I have to do?

All you have to do is to agree to the quotes being used, there is nothing additional for you to have to do.

Will my taking part in the study be kept private and confidential?

Yes, your name and details will not be used in any of the information collected or in any reports. Only anonymous quotes will be used in the report. All information gathered during this project will be coded to ensure that your name and details are not identifiable and it will be stored in a locked cupboard and any computer files used will be password protected.

The only people who will have access to the information gathered will be myself the researcher and relevant staff at the supporting University – Sheffield Hallam University. This will be my project supervisor and members of the research regulation authorities.

All information obtained will be kept securely for 3 years before being destroyed.

What if there is a problem?

If you have a concern about any aspect of this study, you can speak to the researcher, Deborah Wildgoose on [REDACTED] who will do her best to answer your questions. Alternatively, you can speak to her project supervisor: Alex McClimens, who can be contacted on [REDACTED]

If you remain unhappy and wish to complain formally, you can do this through the Trust complaint process. Details can be obtained from any of the ward staff or by contacting:

Trust complaints officer:

[REDACTED]

Or...

Patient Advice and Liaison Service (PALS)

[REDACTED]

What will happen to the results of the research study?

The information will be written up as a report and published for other health professionals to read. It will also be presented to other health professionals as part of a conference aimed at improving services offered to people with mental health needs.

Who is organising and funding the research?

This project is being funded jointly by Rotherham Doncaster and South Humber NHS Foundation Trust and the Yorkshire and Humber Strategic Health Authority and is being overseen by the Sheffield Hallam University.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. They are there to protect your safety, rights, well-being and dignity. This study has been reviewed by the Bradford Research Ethics Committee. You will be given a copy of this information sheet and, if you agree to your anonymous quotes being used in my report, you will be given a copy of your signed consent form for you to keep.

Further information and contact details

Should you wish to have further information about this project, or have any questions or worries please do not hesitate to approach your named nurse or care coordinator or directly to Deborah Wildgoose (Researcher) on [REDACTED] or Alex McClimens (Project supervisor) on [REDACTED]

Thank you for taking time to read this information sheet.

CONSENT FORM – additional information

Study Number:

Patient Identification Number

Title of Project: **The accounts of service users receiving Psychiatric Intensive Care**

Name of Researcher: **Deborah Wildgoose**

Please initial
box

1. I confirm that I have read and understand the information sheet dated May 2013 (version 1) for the above study. I have had the opportunity to consider the additional information, ask questions and have had these answered satisfactorily.

2. I understand that my consent to include anonymous quotes is voluntary. I do not have to agree if I do not want to and that if I decide not to agree, then this decision will not affect the care I receive in any way.

3. I agree to anonymous quotes from the interview I gave in 2012 being used in the study report.

Name of Service User

Date

Signature

Name of Person
taking consent

Date

Signature

When completed: 1 for researcher site file; 2 for participant; 3 to be kept in clinical records.