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**Citation for published version:**

Stenhouse, R 2013, 'Safe Enough in Here?': Patients' Expectations and Experiences of Feeling Safe in an Acute Psychiatric Inpatient Ward' *Journal of Clinical Nursing*. DOI: 10.1111/jocn.12111

**Digital Object Identifier (DOI):**

[10.1111/jocn.12111](https://doi.org/10.1111/jocn.12111)

**Link:**

[Link to publication record in Edinburgh Research Explorer](#)

**Document Version:**

Peer reviewed version

**Published In:**

*Journal of Clinical Nursing*

**Publisher Rights Statement:**

© Stenhouse, R. (2013). 'Safe Enough in Here?': Patients' Expectations and Experiences of Feeling Safe in an Acute Psychiatric Inpatient Ward. *Journal of Clinical Nursing*. 10.1111/jocn.12111

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**'Safe enough in here'?: Patients' expectations and experiences of feeling safe in an acute psychiatric inpatient ward**

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## **ABSTRACT**

**Aims and Objectives:** The study aimed to understand the experience of being a patient on an acute psychiatric inpatient ward.

**Background:** Acute psychiatric inpatient care is an integral part of the mental health system. A key driver for admission to acute wards is risk. Previous research indicates that people do not always feel safe when in an acute ward. Understanding the patient experience of safety can influence nursing practice, as well as policy and service development.

**Design:** A qualitative approach was used. Patient experience was conceptualised as represented through narrative as data. Sociolinguistic theories linking narrative structure with meaning informed the development of the analytic framework.

**Method:** 13 patients with a variety of diagnoses were recruited from an acute ward. Unstructured interviews were carried out in participants' homes two and six weeks post- discharge. Holistic analysis of each individual's data set was undertaken. Themes running across these holistic analyses were then identified and developed.

**Findings:** Participant narratives were focussed around themes of help, safety and power. This paper presents findings relating to the experience of safety. Participants expected to be safe from themselves and from others. Initially they experienced a sense of safety from the outside world. Lack of knowledge of their fellow patients made them feel vulnerable. Participants expected the nurses to keep them safe, and felt safer when there were male nurses present.

**Conclusions:** Participants talk about safety in terms of psychological and physical safety. A key issue was the perception of threat from other patients, highlighting the need to consider patient safety as more than physical safety.

**Relevance to practice:** Nurses need to be sensitive to the possibility that patients feel unsafe in the absence of obvious threat. Institutional structures that challenge patients' sense of safety must be examined.

**Key words:** Patient safety; acute psychiatric inpatient care; nurse-patient relationship; narrative; patient experience

## **INTRODUCTION**

Acute inpatient psychiatric care (acute care) is an integral part of mental health services, providing “*support and treatment*” (Scottish Executive 2006: 10) to those whose “*behaviour or distress requires an immediate response because of the risk of harm to self or others*” (Scottish Office 1997: 45). Risk management is therefore a central feature of the acute ward's role, and dangerousness is one of the main reasons for admission (Bowers *et al* 2003; Bowers 2005). Under UK mental health legislation, risk to self or others is justification for compulsory detention in hospital (Scottish Executive 2003; Department of Health 2007).

Keeping patients safe is a key role of acute care (Delaney and Johnson 2008; Seed *et al* 2010), with much of the responsibility for maintaining patient safety falling to the nurses (Seed *et al* 2010; Bowers 2011). There is an assumption that because risk of suicide is grounds for compulsory detention, admission to acute care will keep the person safe (Bowers 2011). However, the Scottish Government has warned against a narrow focus on prevention of “*untoward incidents and physical harm*” (Scottish Executive 2006b: 24).

Delaney and Johnson (2008) argue that how safety is defined leads to particular markers for measurement, and may narrow the focus of safety related activities. Patient safety is commonly defined in physical terms leading to objective measurement of numbers of incidents (National Patient Safety Agency 2008; Brickell *et al* 2009).

This approach disregards the psychological or emotional impact of being a patient on an acute ward (Delaney & Johnson 2008) which requires consideration of safety as a function of ward milieu; the interaction of a number of different factors both internal and external to the patient. (Delaney & Johnson 2008; Thibeault *et al* 2010; Janner & Delaney 2012). Within this perspective, understanding the patient experience of being on the acute ward becomes a valuable measure of patient safety.

## **BACKGROUND**

Irwin (2006) states that the “*psychiatric ward environment has a direct correlation with aggressive incidence*” (312). Studies have identified poor physical environment (SCMH 1998; Rose 2001; Rogers *et al.*1993), boredom (Higgins *et al* 1999; Walton 2000; Thomas *et al* 2002), lack of therapeutic activities (SCMH 1998; Walton 2000; Ford *et al* 1998; Shattell 2007; Dodds & Bowles 2001), lack of nurse availability (Andes & Shattell 2006; Stenhouse 2011; Higgins *et al* 1999) and lack of therapeutic engagement between nurses and patients (Cleary & Edwards 1999; Bray 1999; SCMH 1998; Baker 2002; Rose 2001; Walton 2000; Ford *et al* 1998; Higgins *et al* 1999; Bee *et al* 2006; Stenhouse 2011) as common features of acute care which can lead to feelings of frustration and not being cared for.

Feeling cared for is linked to the experience of the nurse-patient relationship (Moyles 2003; Coatsworth-Puspoky *et al* 2006; Stenhouse 2011). Coatsworth-Puspoky *et al*'s (2006) ethnographic study revealed that friendliness, spending time, displaying empathy and treating the patient with respect led to the formation of helpful nurse-patient relationships. However, perceiving that their needs were not being met and they were not receiving the necessary support from the nurses led to the development of detrimental nurse-patient relationships characterised by frustration and anxiety.

Nursing activities relating to maintaining a safe environment are generally focussed on formal observation of patients. Such observation activity provides an opportunity for therapeutic engagement with patients (Bray 1999; Scottish Executive 2002). However, nurses and patients have described their experience of observations as a form of social control (Hall 2004; Deacon *et al* 2006; Fletcher 1999).

In a study on refocusing nursing activity away from observation towards therapeutic engagement the number of untoward incidents was decreased (Dodds & Bowles 2001). This supports the notion that aggressive and self harming behaviour are a function of the therapeutic milieu, nurse-patient interaction being an integral part of this as it embodies the ward ideology, and is facilitated by policies and practices (Thibeault *et al* 2010; Delaney & Johnson 2008; Irwin 2006). It is notable that when Thibeault *et al* (2010) asked patients about the environment they wanted to talk about their relationships with the nurses, highlighting their perception of the nurse-patient relationship as a central feature of their experience of the ward.

*Patient experience of safety in acute care*

Patients report feeling safe initially on admission to acute care (SCMH 1998; Thomas *et al.* 2002; Quirk *et al.* 2004; Jones *et al.* 2010) arising from separation from daily stresses of living outside the ward (SCMH 1998; Thomas *et al.* 2002; Quirk *et al.* 2004). In their study of nurses' and patients' perceptions of safety on the acute ward in Taiwan, Sun *et al.* (2006) concluded that being admitted to what they describe as a "protective environment" (87) reduced suicidal impulses.

However, this initial feeling of safety may diminish as patients recognise the threats present in the ward environment, generally from other patients' behaviour (Quirk *et al.* 2004; Jones *et al.* 2010) and sometimes linked with the diagnostic mix of patients on the ward (SCMH 1998; Cutting & Henderson 2002; Kohen 2001; Baker 2002; Sun *et al.* 2006). In a survey of acute, ICU and forensic settings, 15% of acute inpatients (n=707) stated they had experienced an assault whilst on the acute ward (Loubser *et al.* 2009). Aggressive behaviour towards staff and patients was identified in almost half (47%) of patients notes examined during the *Acute Problems* study (SCMH 1998). In their survey of 238 two week admissions, Bowers *et al.* (2003) found that 90% had displayed 'difficult' behaviour at some point, and 81% had been subject to at least one period of containment. Whilst the differing definitions make direct comparison impossible, these figures highlight the prevalence of aggressive behaviour within the acute wards.

Garcia *et al.* (2005) in their national study of acute care, found that 86% of ward manager respondents thought their ward was safe for users and staff. This highlights a potential area of dissonance between the perceptions of patients and staff. Irwin (2006) describes how nurses tend to attribute aggressive behaviour to internal factors

such as illness, whilst patients attribute the causes to relational issues. Such dissonance points to the need for an understanding of the patient experience of safety in order to inform nursing practices if patient safety is going to be considered as an integral aspect of the therapeutic milieu of the acute ward.

This paper reports on the theme of safety arising from a larger narrative study of the experience of being a patient on an acute ward. Understanding the patient perspective can sensitise nurses to problematic issues, influencing nursing practice (Cutcliffe *et al* 2004) and requires direct investigation of the patient experience.

## **METHODOLOGY**

*“If, however, experience is evidence, how can one ever study the experience **of the other**? For the experience **of the other** is not evident to me, as it is not and never can be an experience of mine.”*

Laing 1967: 16 (emphases in the original)

A qualitative design was chosen to investigate the main research question: *What is it like to be a patient on an acute psychiatric inpatient ward?* The study sought to understand the experience of being a patient; Laing’s (1967) problem of knowing the other’s experience was pivotal to the development of the method. Experience was understood as knowable through representation (Riessman 1993), and narrative as the most common form of representing experience (Riessman 1991; Frank 1995; Gee 1985). Individuals interpret events in line with their world view (Polkinghorne 1988) connecting that interpretation with previous experience, constructing narratives to make sense of the world. Such narrative construction occurs in the context of a social



existence constituted of social discourse (Gee 1990, 2005; Gubrium & Holstein 1995; Berger & Luckman 1966). Gee (1990: 143) defines discourse as *“a socially accepted association among ways of using language, of thinking, feeling, believing, valuing, and acting that can be used to identify oneself as a member of a socially meaningful group or ‘social network’, or to signal (that one is playing) a socially meaningful role.”* Membership of particular discourses provides individuals with particular language resources to enable them to narrate their experiences (Gee 2005).

Collecting data using unstructured interviews is congruent with this conceptualization of the link between experience, narrative and discourse. Unstructured interviews allow participants to structure their narratives how they choose, drawing on their own language resources, producing accounts that are close representations of their experience (Thomas & Pollio 2002). The researcher adopts the stance of active listener, using probing questions and reflective statements arising from the participant’s narratives to increase the depth of the data (Rosenthal 2003).

Narratives require interpretation by the audience, and meaning was conceptualized as contextually dependent (Gee 1990, 2005; Werth 1999; Shotter 1993) leading to holistic analysis of narratives. However, interpretation is not the sole responsibility of the listener. Gee (1990) and Shotter (1993) argue that the manner in which a speaker makes a point is instructive of its meaning; emphases and word order indicate what the speaker wants the hearer to note as important (Shotter 1993; Gee 1990, 1991). The analytic process therefore focused on the structure of the narrative, and an analytic framework based on Gee’s (1991) identification of different narrative structures was developed.

Unstructured interviewing allowed participants to avoid or close down issues they did not wish to discuss giving some protection from over-disclosure (Rosenthal 2003; Enosh & Buchbinder 2005). However, recounting and reflecting on the meaning of their experiences might be distressing for participants (Shaw 2003). This does not imply that the interview is harmful (Corbin & Morse 2003, Rosenthal 2003, Dench *et al* 2004) indeed the opportunity to talk about their experiences can be beneficial to participants (Collins 1998, Rosenthal 2003, Corbin & Morse 2003, Gair 2002, Murray 2003). Potential harm, or distress, was acknowledged and steps taken within the ethics protocol to mitigate this.

To facilitate in-depth accounts of their experience, data collection took place away from the hospital environment in a setting of the participant's choosing; all chose to be interviewed at home. Safety issues were considered as part of the ethical review process.

## **METHOD**

### **Participants**

Thirteen participants (6 male, 7 female) aged 18–65 years with a variety of diagnoses and numbers of hospital admissions took part in the study. Participants were recruited from an acute ward in a large psychiatric hospital serving an urban–rural area in Scotland.

Inclusion criteria were: capacity to give informed consent; been on the ward one week or more. Exclusion criteria were: risk of violence to the researcher; being held on a criminal section of the Mental Health Act.

Nursing staff introduced the researcher to patients meeting the above criteria. Patients who were agreeable met the researcher to discuss the research, implications of participation for them and their families, and received written information. Verbal consent was gained from participants while they were on the ward. Participation in the study was confidential; ward staff were not informed of who had agreed to participate.

The study was discussed with 16 patients; 15 agreed to participate. Two were then unavailable for interview and did not respond to further communication, so were excluded from the study.

### **Data collection**

Unstructured interviews, beginning with a broad statement inviting participants to tell their story about being on the acute ward, were carried out 2 and 6 weeks post discharge. The rapport developed during the first interview facilitated deeper exploration of participants' experiences during the second interview (Hollway & Jefferson 2000). All interviews were recorded, and lasted from 45 min to 2 hours.

### **Data analysis**

Data were transcribed verbatim, and transcripts checked with the voice file to ensure best fit (Coates & Thorborrow 1999). Transcripts of first interviews were read and summarized. Summaries were sent to the participants and formed the basis of the

second interview, providing the opportunity for clarification of misunderstandings and deeper exploration of the issues arising from the first interview.

On completion of the second interview, holistic analysis of the total data set for each participant was undertaken congruent with an understanding of the contextual nature of meaning (Gee 1990, 2005; Werth 1999; Shotter 1993). Each data set was conceptualised as a big narrative, inlaid with smaller narratives. The unit of analysis was the small narrative, identified following Gee's (1991) proposition that narratives are prefaced by dysfluencies caused by the narrator organizing his/her thoughts.

These smaller narratives were re-transcribed to make visible the narrative structures identified by Gee (1991) (see box 1) as the means by which the narrator guides the listener's interpretive process (Shotter 1993; Gee 1990, 1991). Analysis focused on these structures. Interpretation of the small narratives weaved together to build the big narrative that represented the participant's experience of being a patient in the acute ward. The product of this analysis was an interpretation of the experience of being a patient for each participant; these were re-presented as poems.

During this process of holistic analysis it became evident that participants had drawn on discourses relating to hospital and psychiatry to make sense of their experience, giving rise to three themes that intertwined throughout their narratives; help, safety and power. Whilst all of these themes were evident in each participant's narratives, each predominantly narrated their experience either drawing on a discourse of hospital as a place of safety and therapy, or a discourse of power in psychiatry. Further analysis of these themes illuminates the participants' experiences in relation to particular aspects of the acute psychiatric inpatient context providing insight for

practitioners and those involved in service or policy development. In this paper I present the theme of safety as it developed through the participants' narratives. In the following section, short sections of data are presented to support the findings as it is beyond the scope of this paper to present entire narratives.

In order to identify the commonalities across the participants' experiences, the holistic analyses were examined and three themes that ran across the entire data set were identified. These themes were help, safety and power. In this paper I present findings relating to the theme of 'safety'.

### **Ethics**

Ethical permission was granted through the NHS ethical review system. Participants were given written and verbal information about the study. Participants had two weeks to consider the implications of participation for them and their families. The researcher and an independent advocacy worker were available to discuss concerns. Participation was voluntary and confidential. Written consent was gained. A list of support agencies was given to participants at interview.

Anonymity was maintained through assignment of pseudonyms. Consent was explicitly sought regarding use of quotations from data. Data were treated in accordance with Data Protection legislation.

### **FINDINGS**

Participants' expected to feel safe on the ward. The experience of safety was bound up with their perceptions of the nurses and the other patients. Participants assessed situations and developed their own strategies to stay safe.

### **“You’re safe enough in here”: Expecting to be safe on the ward**

Participants expected hospital to be a safe place; keeping them safe from others, and their self-destructive impulses. Amanda talked about reminding herself that she was “*safe enough in here*”, implying that she conceptualised the hospital ward as providing a safe environment. Cathy stated that patients had the right to be safe, and this should be formally recognised in a charter.

*“I think that they should have a patients’ charter.  
That’s the thing I thought was missing.*

*A patient’s charter to say that I’ve got the right,  
if I’ve volunteered to go into this hospital,  
I’ve got the right to feel safe.  
And that applies to people who might fear me.”*

Cathy, interview 2

Participants expected to be safe from their own self destructive impulses. James recognised that he could be compulsorily detained under the Mental Health Act if he was actively suicidal. From this he extrapolates a duty on behalf of the hospital to keep people safe from harming themselves.

*“And the thing is, if I tried to commit suicide or eh,  
they would section me.”*

James, interview 2

However, this assumption was called into question when there was a completed suicide on the ward.

*“But again, it’s one of these things that,  
when you’re in [name of acute ward], that you’re thinking about  
‘well, at least I’m safe from not doing something on that scale [reference to acts  
of aggression reported in newspapers]  
either to myself or to other people.’*

*Like I say, that's one of the patients has killed himself...*

James, interview 1

Amanda repeatedly used the phrase *“the system has failed him,”* to convey her sense that being in hospital should prevent a person committing suicide. Her anger was tangible as she stated,

*“And incredibly infuriating ahm,  
that he was supposed to be safe, you know,  
and how bad he was  
and no-one [the nurses] kind of picked up on it*

*But that was his third attempt like,  
which even makes me cross,  
the fact that he had attempted to do it in the ward about a month ago.  
So he was a high risk patient.”*

Amanda, interview 2

Participants therefore expected hospital to keep them safe. Their narratives highlight their expectation that being on the ward should keep people safe from suicidal impulses. The completion of a suicide within this patient group may have brought narratives of this type to the fore as participants tried to make sense of events.

### **Safe from the outside world**

The separation from everyday life created by being in the ward generated a feeling of safety; participants talked about being inaccessible to people they feared, when in hospital.

*“Naebody could get at me when I'm in there sort of thing when,  
I just, everything's just fine”*

Connor, interview 1

This feeling of protection was replaced by a sense of threat from within the ward. Beliefs about people with mental illness being unpredictable, volatile and aggressive left participants feeling threatened by their fellow patients. The language used in their narratives indicates that participants objectified other patients on the ward viewing them as different to themselves: *“the patients”* (Amanda); *“that type of patient”* (James); *“the inpatients”* (Connor).

*“And then, you know, again you were very aware that you don't know how to react with other people.*

*You don't know whether to look at them,  
whether not to look at them.  
You can't ignore somebody,  
will that upset them, you know.  
That is a, I found that really, really quite difficult."*

Jill, interview 1

Participants talked about feeling particularly vulnerable when required to share a dormitory with other patients.

*"I was in a dorm.  
If you're in a dorm it's eh,  
if you're in a dorm it's very difficult because  
you don't know the state of mind of other people"*

Jennie, interview 1

*"This is a massive mental issue.  
You're wanting me to move in with five other strange males,  
only protection being like a pull round cloth.  
I said, 'I don't want to do this.'*

*And it took a lot of talking to me  
and calming me down."*

Peter, interview 1

### **"That's your job": Expecting the nurses to keep patients safe**

Participants expected the nurses to keep them safe, evaluating the nurses' response to aggressive behaviour. They evaluated the nurses' interventions with reference to their assessment of whether the aggression was caused by illness or bad behaviour, and their knowledge of the available resources for dealing with such incidents.

*"Well, there is a secure unit for violent patients,  
and we [the patients] felt he should have been taken to [name of secure unit]. [Name  
of secure unit] is the secure unit for people who are reacting violently  
and [name of acute ward] isn't."*

Jennie, interview 1

Nursing and staff perceptions of when to intervene could differ. Jill described a situation in which she felt she was "stalked" by another patient, indicating how she was moving through the ward constantly trying to get away. The situation culminated in a near assault in the dining room, following which Jill retired to her bed feeling



upset. The language used by Jill when telling this story highlighted the dissonance between staff and patient perception of threat.

*“One of the staff came down, and said, ‘I thought you were upset.’*

*And I said, ‘well, yeah, I just can’t handle that,  
I don’t know how to handle that.’  
I said, ‘she’s been stalk, she’s been,  
there’s just been something,  
she’s been on me’.*

*‘You should have come and told us.’*

*I thought, ‘no, I’m sorry,  
you should have seen that,  
that’s your job.’*

*And he said, ‘you know, we were watching her there,  
we could see’  
and he said, ‘oh well, we’ll keep our eye on things.’”*

Jill, interview 1

Jill made it clear that she expected the nurses to intervene when they observed her being followed. Her perception that the nurse was unwilling to take any positive action is captured in her narration of the nurse’s response; *“we’ll keep our eye on things”*. This statement implies that the nurses did not perceive the situation as requiring their intervention, highlighting a gap between Jill’s and the nurses’ perception of risk.

The expectation that nurses would observe and act on their observations was highlighted by Amanda when talking about the patient who committed suicide. In this excerpt she appears to be asking why, if the patients can see what is wrong, could the nurses, who are trained professionals, not spot it?

*“How could they [the nurses] not have seen that?  
How could they not detect some of that?  
How could they not pull it out of him?  
And we all knew as patients.  
We all knew the façade that he was putting on.”*

Amanda, interview 2

**“I was always glad there was a male on”: perceptions of nurse gender and safety**

Whilst the participants expected the nurses to be able to keep them safe, they identified different ways in which male and female nurses contributed to making them feel safe. Male staff were perceived as providing physical protection.

*“Oh I was always glad there was a male on  
for that simple bit of security for me,  
my safety*

*And sometimes the night shift,  
there was occasions when there wasn't a male member,  
I thought 'oh bloody hell, he's going to go nuts.'  
And again, it was really self protection.”*

Amanda, interview 1

Hospital protocol requiring male staff to leave the acute ward to attend incidents elsewhere supported participants' perception that male nurses offered increased security.

*“If there was any trouble in any other part of the hospital,  
the male nurses in our ward were immediately bleeped,  
so that they could go to where the trouble was.*

*A bit of trouble kicking off in  
some other part of the hospital could end up kicking off trouble  
in our area.*

*And what are they going to do then, when there's none of the male staff there?”*

James, interview 1

In contrast, Connor narrates an event in which he exemplifies his perception that the female nurses cannot offer physical protection to patients. Within this narrative passage Connor also seems to be questioning whether female nurses also require the protection of male nurses:

*“But the next time it happened  
we were in the smoke room  
and five nurses went running past shouting 'help'.  
And I went out and there's [name of patient] coming traipsing up the, up the  
corridor.*

*And I says, 'this is not right,'  
I said, 'that's five lassies'.  
I says, 'who's here for to help them?'  
There was no protection for them at all.”*

Connor, interview 1

Whilst the male nurses were perceived as better able to offer the participants protection from physical threat, the female staff were perceived as offering a quieter, calming effect. Peter described the value of the nurses when he was feeling fearful he might be attacked:

*“Normally a female member of staff would come in with a cup of tea, or take them [other patients] into a quiet room and calm them down, and you thought, ‘these lassies have got their shit together.’”*

*“They really know how to bring someone right down with a quiet supporting word.”*

Peter, interview 1

### **Summary of findings**

Participants drew on a range of discourses about hospital and mental health legislation to underpin their expectation that being on the acute ward should keep them safe.

Whilst some experienced an initial sense of safety from the outside world, participants expressed feelings of vulnerability based on their lack of knowledge of fellow patients, and a discourse that portrays people with mental illness as violent and unpredictable. This was confounded by the expectation that people would sleep in dormitories.

Expectations that the nurses would be able to keep them safe were not fulfilled either because participants experienced dissonance between their assessment of risk and that of the staff, or through their gendered assessment of the ability of the staff to keep them safe. Drawing on gender discourses, male nurses were perceived as offering physical protection, whereas female nurses were perceived as offering emotional support.

### ***Discussion***

The data illuminate dissonance between participants’ expectations and experiences of being kept safe on the acute ward. Mental health policy and legislation supports this expectation (Scottish Executive 2006; Scottish Executive 2003; Department of Health

2007). Through discourse, hospital is constructed as a place where people who are ill or in distress go to get better, this is overlaid in psychiatry by the potential for compulsory detention in hospital on the basis of risk to self or others. Implicit within these discourses is the expectation of patient safety. There is evidence within their narratives that participants draw on these discourses when making sense of their experience of being a patient on the acute ward.

Resonating with other studies, participants experienced a sense of protection from the outside world when in the acute ward (Quirk *et al* 2004; Jones *et al* 2010; Thomas *et al* 2002; SCM 1998). This sense of protection was replaced by an experience of threat arising from perceptions of the other patients and their behaviour (Quirk *et al* 2004; SCM 1998; Cutting & Henderson 2002; Kohen 2001; Baker 2002).

The perception that other patients pose them a risk has two roots: firstly, tension in the ward atmosphere created by patients' actual threatening or aggressive behaviour; secondly, a lack of knowledge of the other patients. This lack of specific knowledge about their fellow patients left participants to rely on discourse – as carrier of social norms and expectations - as the basis for their interactions (Gee 2005). Dominant discourse links mental illness and volatile and aggressive behaviour (Angermeyer & Schulze 2001; Laurance 2003; Anderson 2003). Application of this discourse to their situation led to expectations of volatility and aggression, creating a sense of vulnerability and need for protection from interaction with fellow patients until they had more information upon which to base their actions.

In this study, as in Quirk *et al* (2004), lack of knowledge of others compromised participants' sense of safety when required to share a dormitory. This raises questions about the requirement that people who are suffering psychologically, and may already be feeling vulnerable and anxious, sleep in a room together. It is particularly pertinent given the strong link between experiences of abuse and mental illness (Spataro *et al* 2004; Read *et al* 2005; Mulder *et al* 1998).

Resonating with Thibeault *et al*'s (2010) findings, participants' narratives identify the nurses as central to their experience of safety. Participants in this study expected the nurses to keep them safe whilst they were on the ward. However, there was a gender

dimension to this; drawing on a discourse that portrays men as possessing strong and protective attributes, the participants indicated that they felt safest when there was a male member of staff on the ward. Evidence to support this gendered perception was provided by hospital policy; male nurses required to attend incidents on other wards. Both patient perception and institutional policy highlight the concept that aggression requires physical intervention.

Contrastingly, there is a view that the use of interpersonal skills can de-escalate aggression (Irwin 2006; Quirk *et al* 2004). This focuses nursing activity towards nurse-patient interaction, and identification and assessment of the potentially aggressive situation. Underpinning the identification of risk is the nurses' perception of the level of threat; this may differ from the patients' perception of threat (Rossberg & Friis 2004; Quirk *et al* 2004).

Just as patients draw on a discourse linking aggression and mental illness, so too might the nurses, creating normative expectations of higher ambient levels of aggression (than would be the norm outwith the acute ward) in an environment where patients have acute mental illness. Working from within different discourse frameworks therefore leads to dissonance between staff and patient perceptions, leaving patients feeling unsafe when staff do not react in the manner they expect to keep them safe.

Considering narrative as a means to know the other's experience, then the development of a nurse-patient relationship where the nurse can explore the patient's experience of threat/safety can help bridge this gap. This requires the conceptualisation of patient safety as something which extends beyond the objectively measurable to that which is integral to the patient's experience of the ward milieu, inextricably bound up in nurse-patient interaction.

The evidence from the data is that the participants often felt unsafe, and were unsure that the staff could keep them safe. This raises the question of whether an environment in which patients do not feel safe is conducive to promoting recovery from mental illness.

## **CONCLUSION**

Participants made sense of their experience of the acute ward by drawing on their knowledge of the psychiatric system and social discourse. This sense making process has implications for how they interact with the environment, nurses and other patients. The discourses upon which participants drew perpetuate widely held beliefs about mental illness, psychiatry and hospitals, and are available to nurses and patients. Awareness of this process by which patients make sense of being on the acute ward might sensitise nurses to possible interpretations, and therefore the potential impact of being on the ward. Such sensitivity can shape nursing interactions with patients as a basis of understanding their experience and facilitating a sense of safety.

Participants' narratives about safety were about both physical and psychological safety. They identified the relational aspect of this, highlighting the need to attend to nurse-patient relationships with the aim of improving the experience of safety. Dodds and Bowles' (2001) work supports this.

The most commonly identified safety issues related not to direct physical safety, but to psychological safety; arising from perceived threat, fear of others, perceived lack of support from the nurses, different perceptions of threat. This points to the need to consider safety in terms not only of objectively measurable outputs such as untoward incidents or drug errors, but to consider the psychological stresses experienced by people who become patients on the ward. Structural issues such as placement in dormitories require examination, especially in light of the strong links between experiences of abuse and mental illness.

## **IMPLICATIONS FOR PRACTICE**

Nurses need to be sensitive to the possibility that their patients feel unsafe, even in the absence of obvious direct physical threat. Developing relationships with patients where they can discuss their fears and feel supported might decrease the psychological impact of being on the ward.

Nurses need to examine ward/hospital practices that challenge patients' sense of safety; placement in dormitories or male staff running to incidents.

Awareness of the patients' need to make sense of their experience through application of discourse should sensitise nurses to their possible interpretation of events. Such interpretations, based on discourse rather than specific knowledge of the situation, can lead to erroneous interpretations and the perception that the nurses are unable to keep them safe. These could be managed through debriefing with patients following an incident, acknowledging the patients' need to make sense of the experience, and facilitating their sense of safety.

#### LIMITATIONS OF THE STUDY

This study presents a snapshot of the experience of a small number of participants within a particular historical and social context. The chosen methodology supported the development of a deep contextualised understanding of experience which can sensitise readers to the possible experience of others in similar situations, but are not directly transferable across other contexts.

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Box 1: Analytic framework based on Gee's (1991) theories of how narrative structure is used by the narrator to construct meaning

<b>Narrative structure</b>	<b>Interpretive function</b>	<b>Notation</b>
Lines and stanzas	Present a perspective on an event or character like a single camera shot.	Organisation into poetic structures of line and stanza based on careful listening for changes of topic or perspective, and to pauses to identify the end of a line/stanza
Syntax and cohesion	Connections between different elements of the narrative for example indicating understanding of how one event led to a particular consequence.	
Grammar	Indicates the point of view of the narrator, for example, regarding past/present/future or relationship to characters within the narrative ('I', 'we', 'they').	
Pitch and stress	Used by the teller to assert something as new or important information upon which the listener should focus.  Examination of this material within a narrative enables themes and images to be identified. These are used support the development of the interpretation.	Careful listening to identify pitch glide understood to denote new information. Made visible by use of UPPER CASE within transcription.

Adapted from Gee (1991): 27