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ORIGINAL ARTICLE

Exploring safety culture within inpatient mental health units: The results from participant observation across three mental health services

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Abstract

In Australia, acute inpatient units within public mental health services have become the last resort for mental health care. This research explored barriers and facilitators to safe, person-centred, recovery-oriented mental health care in these settings. It utilised participant observations conducted by mental health nurses in acute inpatient units. These units were located in three distinct facilities, each serving different areas: a large metropolitan suburban area in a State capital, a mid-sized regional city, and a small city with a large rural catchment area. Our findings highlighted that, in the three inpatient settings, nurses tended to avoid common areas they shared with consumers, except for brief, task-related visits. The prioritisation of administrative tasks seemed to arise in a situation where nurses lacked awareness of alternative practices and activities. Consumers spent prolonged periods of the day sitting in communal areas, where the main distraction was watching television. Boredom was a common issue across these environments. The nursing team structure in the inpatient units provided a mechanism for promoting a sense of psychological safety for staff and were a key element in how safety culture was sustained.

KEYWORDS
clinical practice nursing research, mental health, mental health services, safety culture

INTRODUCTION

Acute inpatient units in public mental health services are now a place of last resort for mental health care in Australia (Fletcher et al., 2019; Isobel, 2019). In these units, staff support people deemed to be of high risk to themselves and/or to others and who are viewed as no longer suitable for community mental health team support (Beckett et al., 2017). These admissions are intended to promote recovery and safety (Cutler et al., 2021). Mental health staff working in these clinical areas are required to engage in person-centred, recovery-oriented practices (Australian College of Mental Health Nurses, 2010; Commonwealth of Australia, 2010). This practice places the consumer's need to be at the centre of mental health care to support their personal recovery towards a meaningful and contributing life with or without the presence of mental health issues (Commonwealth of Australia, 2010; Hornik-Lurie et al., 2018). While practice meets these needs in many settings, inpatient units have also been identified as depersonalising environments, with low utilisation of effective therapeutic practices (Phipps et al., 2019; Wilson et al., 2017). In some cases, high levels of acuity and limited mental health skills among staff

have been linked to an inability of these units to provide even the most basic levels of mental health care, such as a safe environment and engagement with nursing staff (Allison et al., 2015; Fletcher et al., 2019; Wilson et al., 2017).

Nurses working in mental health contexts view safety as paramount to their role and this value shapes their nursing practices and clinical judgements (Slemon et al., 2017; Wyder et al., 2017). This accords with their practice in inpatient mental health services, where the overriding concern is to provide a safe environment for consumers and avoid critical incidents, including suicides and assaults (Beckett et al., 2017; Mullen et al., 2022). The primacy of safety has the potential to create a culture of high risk aversion that can erode clinicians' capacity to deliver recovery-oriented care (Wyder et al., 2017). In this context, nursing roles become increasingly narrowed and the safe containment of consumers dominates all aspect of practice, including the provision of therapeutic interventions (Wilson et al., 2017). Therefore, safety culture and its expression in individual nurses' practice is a key factor in influencing the balance between restrictive and therapeutic practices within inpatient units (Muir-Cochrane et al., 2018; Price et al., 2018).

BACKGROUND

An organisation's culture has been identified as a determinant of safe practice and quality of care (Alanazi et al., 2022; Hamaideh, 2017). This aspect of organisational culture has been explored in the concept of *safety culture* (Thibaut et al., 2019). Safety culture has been defined as 'the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour, that determine the commitment to, and the style and proficiency of, an organisation's health and safety management' (Health and Safety Commission, 1993, p. 23). In the context of health service provision, it involves a shared responsibility for ensuring care is delivered in a safe way and where there is a constant focus on ensuring safety within the organisation (Arzahan et al., 2022; Hamaideh, 2017). Alanazi et al. (2023) have identified that health care organisations that have well-developed safety cultures are usually those that report higher quality care (Alanazi et al., 2023).

There is limited research with a specific focus on practice culture as it relates to safety within inpatient mental health units, with the majority utilising quantitative methods (Alanazi et al., 2022; Thibaut et al., 2019). These studies have focused on staff perceptions of safety culture in their work environments (Alanazi et al., 2022; Thibaut et al., 2019). While in other literature related to safety in inpatient units, there is a strong emphasis on aspects of this area, such as staff safety and critical incidents such as self-harm and assaults (Doedens et al., 2020;Taylor-Watt et al., 2017). These areas are important for practice development, but a narrow focus on elements of safety does not consider the many social factors that influence safety within inpatient units (Molloy et al., 2017). Qualitative methodologies can provide an in-depth understanding of the social situation being studied (Schwandt, 2015). These approaches to research can provide insights into the interactions between staff members and consumers that influence safety culture and developing understandings of attitudes and behaviours that exist within it (Eldal et al., 2019; Jenkin et al., 2022). By focusing on safety culture in three inpatient units in Australia, this research aimed to understand any barriers and facilitators to safe person-centred, recovery-oriented mental health care in these settings.

Ethics

The study was approved by the Northern Sydney Local Health District: HREC/18/HAWKE/148, Illawarra-Shoalhaven Local Health District: 2018/428, Western New South Wales Local Health District: GWAHS 2018–107, and University of Technology Sydney: ETH19-3445. Governance approval at all sites was also obtained.

METHODS

The data collection for this study took place over June 2019 to December 2020 as part of a large mixed-method action research project focused on improving safety culture within three inpatient settings. The project's initial fieldwork involved 8-h days (08:00–16:00), 2 days per week, for a total of 4 weeks. The results of the observations in the inpatient units are being reported separately due to the amount of data generated. For this component of the research, data collection utilised observational fieldwork to understand the safety culture on the units (Van Maanen, 2011). Data was recorded in field-notes (Emerson et al., 2011). This method of data collection allowed the researchers to access a rich diversity of information about safety culture in the inpatient units (Hammersley & Atkinson, 2007). This approach to data collection helps broaden understandings of the phenomenon of interest and enables thick description in the data (Molloy et al., 2015).

Observational fieldwork is a form of inquiry in which the researcher is 'immersed personally in the ongoing social activities of some individual or group for the purposes of research' (Wolcott, 2005, p. 58). Observation provides a method for gaining a contextualised understanding of social behaviour (Hammersley & Atkinson, 2007) and can generate an analysis of the social world (Geertz, 1973). The fieldwork in this study involved observations in three acute inpatient settings. These included services covering a large metropolitan suburban area in a State capital, a mid-sized regional city

and a small city with a large rural catchment area. The researchers who undertook the observations where mental health nurses who had fulltime roles in these mental health services (although not in the units that were observed) and were seconded to the research project. The nurse researchers had regular meetings with the wider research team to reflect on their fieldwork experiences and explore potential biases in their observations.

Fieldnotes are the written account created by the researchers that record their reflections, observations, and experiences during the research (Emerson et al., 2011). They are intended to produce an understanding of the social situation being studied (Schwandt, 2015). During observational fieldwork, researchers would write notes at regular points in the day and would later record detailed fieldnotes about their observations after leaving the sites. The fieldnotes contain descriptions of interactions with people that included staff and consumers, observed practices, the physical environments, organisational routines encountered, and reflections at the three sites. Although the data may be qualitatively different, taken together, they can provide the basis of an analysis of how the social worlds of inpatient units are constructed (Latimer, 2008). Thematic analysis was deemed the most appropriate analytic strategy for fieldnotes (Braun & Clarke, 2006). Data from the fieldnotes from the three units were grouped together to explore similarities and differences in the observations and reflections in the researchers' fieldnotes. These data were analysed through Braun and Clarke's (2006) six-step approach to thematic analysis. The fieldnotes were read several times to ensure familiarity. They were then subjected to line-by-line inductive coding. Initial codes were generated from the content of the fieldnotes. These were organised into coherent themes based on their congruence with the other codes. To promote trustworthiness, the findings are presented within these themes with reference to the fieldnotes to provide evidence of the findings (Braun & Clarke, 2006).

Findings

Exploring the similarities and differences within the observations recorded in fieldnotes, three themes were identified from the notes: 'Team and relationships', 'Boring wards', and 'Staying in the office'. Each individual unit is not noted in the data as it may lead it being identifiable. However, the fieldnotes from different sites are identified as *, ** and ***.

Team and relationships

In our study, it was observed that team membership shaped individual nurse's perceptions of safety on the units and influenced the patterns of behaviours of safety culture among nurses. For example, experienced nursing staff were identified by one staff member as being key enablers for promoting safety culture within the practice environment.

> The experience of nursing staff and the stability in the team were also factors the nurse identified in relation to promoting safety.
>
> ***Fieldnotes 2/7/19

The interactions within their teams provided nurses with support. Team members used verbal and non-verbal communication to communicate care towards their colleagues when critical incidents occurred. It was observed that the teams provided a mechanism for promoting a sense of psychological safety for team members.

> I observed over the course of the morning shift that all other staff members 'checked in' with their colleague in their own way. Some offer a hug, others a drink but every member of the team made sure they found a way to offer support … It made me realise that teamwork here goes well beyond the initial incident, and to the debriefing and coping stage.
>
> *Fieldnotes 11/10/19

> The clear warmth and value shown between colleagues reinforces my existing impression that the working relationships here are positive and powerful.
>
> *Fieldnotes 7/10/2020

With this psychologically safe space, key elements of safety culture were sustained, and practice developed. Within office spaces, staff appeared comfortable to voice their concerns about the clinical environment. Nurses shared their ideas about consumer care and listened to the perspectives of others. This created a situation of shared decision-making that strengthened the team cohesion.

> A positive impact was that it created a cohesive team that promoted open communication and a safe space to shared perspectives on care with the units.
>
> ***Fieldnotes 22/7/19

> It was noticeable that clinicians who involved in the handover today were quite comfortable. Each member raised their opinions without hesitation while others listen to their colleagues' idea with great respect. By observing their communication interactions, I can see their team cohesion is quite strong and supportive.
>
> ***Fieldnotes 16/7/19

However, beyond the group of registered nurses who provided care, fractures were observed between those groups and nurses who managed aspects of services. With more power, nurse managers seemed more distant from the nurses working in the units.

> Starting to feel like this 'Us and them' attitude usually between patient and nursing staff also applies to nursing staff and management.
>
> **Fieldnotes 29/8/19

> There is a feeling that some of the After-Hours [Nurse] Managers are disengaged from the workforce…
>
> *Fieldnotes 27/10/20

Unit nurses also identified issues with connectivity within the multidisciplinary team. Nurses felt ignored in relation to their practice and were left out of key decisions that impacted upon their practice.

> The working relationship with the medical staff in particular seems to have its challenges. Staff speak about feeling that their concerns aren't heard because of a lack of action from other staff at times. This week has been particularly tricky they think there have been a number of difficult interactions and challenges within the team…
>
> *Fieldnotes 30/10/20

> There is discussion of the plan involving nursing staff, but no involvement of nursing staff in the conversation.
>
> *Fieldnotes 12/10/20

This disengagement meant that nurses were disconnected from key issues which caused frustrations for the people they were providing care to. They would not address these issues but would tell them to follow them up with the medical team, who were often very difficult to access on the units.

> As for other things like patients feeling frustrated about their treatment plan or leave time, the nurses would refer back to 'the doctors'.
>
> ***Fieldnotes 16/7/19

Boring wards

Consumers spent prolonged periods of the day sitting in communal areas, where the main distraction was watching television. Time was punctuated by the routines around mealtimes and medication administration, then later, bedtime. These spaces had the feel of a waiting room, with people sitting in chairs, often facing away from each other. Conversations between consumers were often muted by loud sounds from the television. Occasionally, someone would be called off for a team review. They would be back after 30 min or so. Boredom was a common issue across these environments.

> Today I have had conversations with some consumers. The most common theme I get from them is that they feel bored because they haven't anything to do.
>
> ***Fieldnote 9/7/19

One of the contributing factors for the boredom that was identified by people on the units was a lack of activities. This was not just a lack of structured therapeutic groups, but a lack of any staff-initiated diversional activities. What groups were available were delivered by allied health staff and peer workers in the earlier part of the day. Nurses rarely facilitated activities; some would provide access to art resources or briefly play games such as table tennis. The solution to the boredom seemed obvious to consumers, with one person saying:

> I think there should be more activities in the ward… There are not enough activities for patients during the day.
>
> ***Fieldnotes 16/7/19

However, across the units where practice was observed, many nurses did not see an importance in therapeutic engagement and did not prioritise such approaches within their practice or the ward routines. One research lead observed:

> They don't know why running groups are important. Or even why engaging with the consumer is important. That is how basic it is.
>
> **Fieldnotes 29/11/19

In these circumstances, local research leads found that people appreciated conversations with them as they carried out their research roles. The researchers found themselves to be welcome distractions, noting:

> Most consumers are happy to talk as there is not much else to do.
>
> **Fieldnotes 4/10/19

It was noticeable that people seemed happier when the nurses spent time talking with them. Most interactions were brief and focused on aspects of nursing tasks, such as organising leave. The lack of engagement and the minimal quality of the interactions was an issue for people on the ward, and it had consequences within their care environments and their safety. One consumer commented:

> I noticed patients became frustrated because the nurses don't talk to them. Some of the problems could be dealt with if the nurse spent time to explain things to the patients.
>
> ***Fieldnotes 16/7/19

However, just as facilitating groups was not seen to be a priority in nursing practice, one-to-one interactions was not prioritised over the daily tasks of nursing. A local research lead observed:

> The nurse sighs and explains there doesn't seem to be time in the nurse's day to do thing they think are important…
>
> I'm left wondering if the nurses would rather do other things- they don't seem happy to just do documentation. Do they lack skills? Is it prioritisations of their time? Are they supported? Why isn't it clear what their role is?
>
> *Fieldnotes 11/12/20

Staying in the office

Work activities carried out in the unit's office were a key barrier for consumer engagement identified by staff. Nurses viewed procedural activities such as documentation dominating their practice time, and that this kept them from person-centred practices that could be undertaken outside of this space. Researchers observed that this occurred across the three sites and shaped safety culture and care delivery in these settings.

> I am starting to notice that staff spend a lot of time in the office…
>
> **Fieldnotes 13/6/19

> The nursing staff appeared wholly taken up by administrative tasks inside the office, with the doors closed tight, and no way to make communication for the consumers.
>
> *Fieldnotes 8/1/20

> She also describes the significant barrier for her to engage with patients meaningfully is the amount of paperwork… 'sometimes I try to explain to the patient the amount of work I do for them on computer is enormous (referring to activity-based funding system). That is why I could not physically engage with them. I don't think they understand that, though'.
>
> ***Fieldnotes 16/11/20

For some nurses, the documentation requirements of their nursing practice were seen to have become the core responsibility of their role, eclipsing consumer engagement. While most staff identified this imbalance, no one was observed to be challenging this.

> I ask what the nurse's role appears to be and they shrug 'mainly documentation and medications'.
>
> *Fieldnotes 12/12/19

> The nurse is explaining the amount of paperwork required for the unit is considerable and sometimes it feels that this is all they do.
>
> *Fieldnotes 14/10/2020

While office work was a key reason for being in the office, researchers observed that these spaces became places were nurses spent most of their time, regardless of their activity. In the office, staff became distant figures to the consumers. Occasionally interacting with them, nurses were more often only visible behind the office windows. This created an interpersonal disconnection that was clear to the consumers.

> The consumer tells me that the staff are not often out here. I look back into the building and through two sheets of glass can see nurses staring at computers screens.
>
> *Fieldnotes 12/12/19

> 10:30 am: 4 nurses were sitting in the nursing station. One of the nurses decided to leave to check her patients. She stated, 'Alright I'm going to check my peeps and see how they are going'. She then quickly returned to the nursing station.
>
> ***Fieldnotes 4/6/19

> All four members of staff in the office. Some busy writing notes.
>
> **Fieldnotes 20/9/19

> During this time, it was noticeable that the nurses spent most of their time in the nursing station. Nurse and patient interactions only occurred during medication administration, checking vital signs and attending observations charts. The patients mostly spent their time watching TV and wandering in the outside area.
>
> ***Fieldnotes 13/7/20

The dominance of the office space as their primary workspace for nurses had implications for safety on the units. There were many periods throughout the day were there were no nurses in the areas outside of this

environment and consumers spent long periods without connecting with a staff member. Soundproofing within the offices to keep sound out of the ward meant that many situations which required nurses to intervene had escalated in the absence of a staff presence outside of these spaces.

DISCUSSION

In line with quantitative studies on this area, our qualitative findings highlight the importance of the nursing team as an enabler of safety culture in the hospital setting (Alsabri et al., 2022; Berry et al., 2020). While it has been previously noted that mental health nurses need experience to maintain safety (Higgins et al., 2018), our findings show that this experience also enables those with less experience to feel safe in the practice environment. This is nurtured through interactions within nursing team, which provide crucial support and foster a sense of psychological safety for team members. Psychological safety is viewed as particularly important enabler of safety culture in high-risk environments (O'Donovan & McAuliffe, 2020). The team support observed extended beyond immediate incidents, nurturing a culture of ongoing support and debriefing, underpinning the development of safety culture (Alshyyab et al., 2021). This development was also enabled through the presence of a safe spaces where nurses were comfortable to express concerns and engage in collective decision-making, key elements in the development of safety culture (Tangatarova & Gao, 2021; Tear et al., 2020). Schisms were observed between registered nurses providing direct care, their medical colleagues and nurse managers which provided an insight into the barriers to safety culture within the wider organisational safety culture that the units were situated in. These disconnections which resulted in nurses feeling distanced from key safety issues, highlighted the negative impact that health care hierarchy can have in ensuring safety culture at an organisational level (Tear et al., 2020).Nurses are the key mental health professional group for ensuring the people admitted to inpatient units receive safe person-centred, recovery-oriented mental health care in inpatient units (Roche et al., 2021). Their actions and practices shape the therapeutic environment experienced by consumers and nurture safety culture in this setting (Merrick et al., 2022; Zugai et al., 2018). Our findings highlighted that across the three inpatient settings, a key barrier to safety culture was nurses were mostly avoidant of common areas they shared with consumers, except for quick task-related visits. This had clear implications for the therapeutic engagement of consumers and strategies for improving safety culture in the organisations. Mirroring society more broadly, and contrary to the ideas of recovery, consumers experienced social exclusion within these settings as they were observed through the glass of office windows by a distant workforce (Wrycraft & Coad, 2017). The findings support the criticism of inpatient units being potentially depersonalising environments (Beckett et al., 2013; Phipps et al., 2019; Wilson et al., 2017). However, it was not observed that these circumstances occurred from an active attempt to leave consumers feeling disengaged by mental health nurses. These issues seemed to stem from a lack of awareness about nurses' potential impact on the clinical environment and their potential for fostering a positive therapeutic milieu for consumers through their presence. While viewed as key aspect of the nursing role and a major contributor to consumer outcomes, there remains a limited evidence-base to support mental health nursing practice in developing and maintaining therapeutic relationships in inpatient settings (Hartley et al., 2020; Moreno-Poyato et al., 2021).

The safety culture observed by the researchers had been shaped by privileging office-based, administration activities over person-centred care (Lakeman, 2020). The need for inpatient mental health nurses to spend more meaningful time with consumers in joint activities has been identified in research and in policy (Molin et al., 2021; State of Victoria, 2021). However, it has been noted that there is an imbalance in the amount of nurses' time given to activities that do not involve consumer engagement (McAndrew et al., 2014). Lack of meaningful engagement has been associated with several factors affecting nurses, including a lack of time, competing administrative commitments, and a lack of knowledge of appropriate methods of engaging with consumers (Dodd et al., 2018; Hartley et al., 2020; Roche et al., 2011). In our research, nurses identified that administrative tasks dominated their workloads, but there appeared to be little acknowledgment about what the nurse's role should be when engaging consumers. The dominance of administration appeared to occur in a situation where nurses had no sense of the practices and activities they could be doing as an alternative (Guha et al., 2022). The units lacked clear structures to support therapeutic engagement with consumers and although services were expected to be recovery-orientated, what this meant for nurses working in the inpatient setting was not clear in the units' routines. The tasks related to medication administration were clear and received priority.

Gunasekara et al. (2014) have highlighted a need for renewed attention to the basics of relationships between consumers and staff in inpatient mental health units. This engagement provides a basis for recovery-oriented care with consumers (Polacek et al., 2015) and can be a key enabler of safety culture in inpatient settings (Hartley et al., 2020; Moreno-Poyato et al., 2021). One response to this situation has been the development of ward procedures to support one-to-one engagements between nurses and consumers, such as protected engagement time (PET) (Nolan et al., 2016). During PET, ward routines are adjusted so that nurses can spend time together with consumers without

interruption. The time for engagement is privileged and given a clear priority in practice. There was a clear need for PET in the sites in the present study, to increase nurse and consumer interactions, and ultimately improve the therapeutic environments within inpatient mental health units.

While PET can impact the quantity of engagement, combining this with clinical supervision can also enhance the quality of consumer engagement (Hamilton et al., 2023). Regular supervision sessions provide nurses with an opportunity to reflect on their practice and refine their therapeutic skills (Cutcliffe et al., 2018). Clinical supervision supports an approach to nursing practice that is person-centred, and recovery-orientated (Hamilton et al., 2023). This provides nurses with a platform to discuss and reflect on their approach to PET, leading to continuous professional development (Ernawati et al., 2022). As nurse's gain confidence through supervision, they are empowered to improve the quality of their engagement with consumers, contributing to the overall safety culture and therapeutic milieu of inpatient units (Cutcliffe et al., 2018).

CONCLUSION

Limited interactions between nurses and consumers in inpatient settings create a barrier to both safety culture and person-centred recovery-oriented care. This study explored the role of nursing teams in supporting safety culture in inpatient settings and found that factors like extended periods spent in offices away from consumers and a lack of engagement on the units negatively impact safety culture. While a heavy administrative burden contributed to reduced contact, the study suggests that factors like nurses' engagement skills and a culture promoting interaction at all levels of the organisation are even more crucial to fostering safety culture.

The study has limitations when appraising the findings relevance to other settings. While attempting to represent services across a variety of setting, all where within one health service. The observations were also carried by staff from those services, which may influence the way they view those practices. Further qualitative research is needed on understanding the area of safety culture in other acute inpatient setting to see if similar issues are found outside of this service. Further research is also needed on the phenomenon of office work in the inpatient setting beyond our limited focus on safety culture.

RELEVANCE TO CLINICAL PRACTICE

This research highlights the critical role that nurses play in shaping safety culture and fostering person-centred. recovery-oriented care within very challenging practice settings. Strong team support and open communication are key enablers of a positive safety culture. However, limited engagement with consumers, often related to administrative workload and unclear role expectations, emerged as significant barriers within practice. To address these challenges, there is a clear need to prioritise meaningful engagement in inpatient care, utilising interpersonal structure like PET and clinical supervision. This can form the basis for shifting mental health nursing practice away from office-based tasks to person-centred recovery-orientated care. Ultimately, this refocus can empower nurses to create safer, more therapeutic inpatient environments for consumers.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interest to report.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

Ethics approval for the research was received from: Northern Sydney Local Health District: HREC/18/HAWKE/148. Illawarra-Shoalhaven Local Health District: 2018/428. Western New South Wales Local Health District: GWAHS 2018-107. University of Technology Sydney: ETH19-3445.

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