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Nurses’ views highlight a need for the systematic development of patient safety culture in forensic psychiatry nursing

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**Background:** Although forensic nurses work with the most challenging psychiatric patients and manifest a safety culture in their interactions with patients there have been few studies on patient safety culture in forensic psychiatric nursing.

**Objectives:** The aim of this qualitative study was to describe nurses’ views of patient safety culture in their working unit and daily hospital work in two forensic hospitals in Finland.

**Methods:** Data were collected over a period of one month by inviting nurses to answer an open-ended question in an anonymous web-based questionnaire. A qualitative inductive analysis was performed on nurses’ (N=72) written descriptions of patient safety culture in state-owned forensic hospitals where most Finnish forensic patients are treated.

**Results:** Six main themes were identified: ‘Systematization of an open and trusting communication culture’, ‘Visible and close interaction between managers and staff’, ‘Non-punitive responses to errors, learning and developing’, ‘Balancing staff and patient perspectives on safety culture’, ‘Operational safety guidelines’, and ‘Adequate human resources to ensure safety’.

**Conclusions:** The findings highlight the influence of the prevailing culture on safety behaviors and outcomes for both healthcare workers and patients. Additionally, they underline the importance of an open culture with open communication and protocols.

**Keywords:** Patient safety culture, patient safety, forensic psychiatry, psychiatric nursing
INTRODUCTION

Patient safety has been recognized as a key driving force in healthcare and has received considerable attention from healthcare administrators. Several studies have noted the importance of safety culture in health care safety, and it has been demonstrated that patient safety culture is related to patient outcomes. The organization’s culture, which is formed interactively by the management, staff, and patients, is a critical patient safety factor in psychiatric care. Despite its importance, however, implemented interventions frequently fail to address the true sources of errors and accurately target weak organizational safety cultures.

Psychiatric inpatient-care patient safety studies have focused on near misses and clinical risk management (CRM). The main CRM-related concerns in the context of mental health are a) violence and self-destructive behavior (self-harm), b) treatment errors, especially in the process of therapy, and c) risks associated with mental illnesses. In the context of forensic psychiatry, previous studies have shown that patients’ perspectives received insufficient attention during seclusion/restraint processes and generally were not well-reflected in personnel’s perceptions of safety. In addition, studies on patient seclusion and restraint have shown that systemic efforts to reduce the use of institutional measures of control can be effective.

In recent years there has been increasing academic interest in the influence of patient safety culture on the views of nursing managers and staff members. Nurses play essential roles in ensuring patient safety because they account for a large majority of healthcare personnel and are responsible for ensuring that patients receive safe care in an accident-free environment. Forensic nurses work with the most challenging psychiatric patients and manifest a safety culture in their interactions with these patients. Moreover, because of their central roles in safety processes on their wards, nurses have a unique position that allows them to observe patient safety directly. However, patient safety culture in forensic psychiatric care has not been studied extensively, so
there is a need to characterize existing patient safety cultures in forensic nursing in order to identify opportunities for their development and improvement.

**METHODS**

**Aim**

The aim of this qualitative study was to describe forensic nurses’ views of patient safety culture in their working unit and daily hospital work.

**Ethics**

The Research Ethics Committee of the Hospital District evaluated our study’s design to identify potential ethical issues and granted permission for it to be conducted. All participants were given written documentation explaining the study’s purpose and that participation was both voluntary and anonymous.

**Study settings**

This study was carried out in Finland, which has two state-owned forensic psychiatric hospitals with 449 beds and approximately 570 members of nursing staff between them. The main function of these mental hospitals is to perform forensic psychiatric evaluations and provide treatment to patients who are violent offenders found not guilty by reason of insanity and those who are too dangerous or difficult to be treated in regional hospitals. These patients represent a highly select group, and nearly all of them suffer from schizophrenia, most often the paranoid form of the disease. The majority of the patients have a history of severe violent behavior and aggressiveness as well as substance abuse problems, which often continue despite regular treatment. The patients’ aggressive and suicidal acts are often sudden and unpredictable.
Data collection and analysis

Data were collected over a period of one month by inviting nurses to answer an open-ended question in an anonymous web-based questionnaire that was created as a part of a larger study on the two Finnish forensic hospitals. The aim of the larger study was to evaluate patient safety culture in state hospitals in Finland based on the Hospital Survey on Patient Safety Culture questionnaire, which was completed (in whole or in part) by 283 nurses. Seventy-two of these respondents answered the open-ended item “Write about your experiences and views on patient safety, errors and reporting of safety incidents in your hospitals”. The respondents were free to write as they saw fit about their experiences and views relating to patient safety. Nurses from multiple different wards chose to answer the open question, providing details of their views on patient safety in forensic nursing and related factors. As such, the data cover a wide range of perspectives and the response texts are multi-dimensional. The qualitative descriptive approach of inductive content analysis was used to describe the forensic nurses’ individual, subjective and contextual perceptions, experiences and meanings relating to patient safety, and to make replicable and valid inferences about providing safe care in forensic nursing contexts. A stepwise analytical process was adopted in which the author AK initially read each text through several times in order to obtain an overview of the material as whole and select the unit of analysis, which was chosen to be the sentence. The analysis then proceeded from the identification of concrete meaning units to that of sub-themes and finally main themes. This was followed by a discussion between the authors AK and HT to enhance inter-rater reliability and improve interpretative validity. Finally, the results were discussed within the research group in order to further enhance the validity of the analysis. In addition, we followed the COREQ (Consolidated criteria for reporting qualitative research) 32-item checklist for qualitative research involving the analysis and description of complex phenomena including the subtleties and complexities of collected human responses.
RESULTS

Six main themes influencing patient safety in forensic psychiatry were identified: ‘Systematization of an open and trusting communication culture’, ‘Visible and close interaction between managers and staff’, ‘Non-punitive responses to errors, learning and developing’, ‘Balancing staff and patient perspectives on safety culture’, ‘Operational safety guidelines’, and ‘Adequate human resources to ensure safety’.

Systematization of an open and trusting communication culture

The nurses’ reflections suggested that an open communication culture and being able to talk about errors gradually improved patient safety culture. However, some of the responses revealed a lack of systemic ways of discussing errors in the hospitals’ working units.

“People have become more willing to talk about issues as they are, for example by discussing errors.” “We sometimes do well at objectively discussing errors with coworkers in our unit, but practices are very variable.”

In addition, the nurses highlighted a need for better communication and an open atmosphere at the organization level:

“In order to improve patient safety, an open atmosphere that prioritizes developing functions would be needed.”

Visible and close interaction between manager and staff

The participants generally expressed a wish to interact more closely with managers and other staff, suggesting that this would increase mutual understanding and create a sense of being listened to. It would also improve managers’ understanding of nurses’ work and prevent provocativeness, bringing a sense of community to the entire hospital.
“…staff should have closer interactions with the management of the work place. This would prevent things like misunderstandings and overreactions, and would bring communality and team spirit to the entire building”.

“There is a lot of friction and mistrust on both sides! The working atmosphere and spirit relating to administration are poor”.

The nurses also wanted the nurse managers to update their knowledge about the reality of forensic nurses’ working environment by interacting with nurses in wards. In addition, nurses expected transparent decision making and justifications in general.

“… just for a couple of days, come and see what this work at the ward is really like”. “It would be favorable to have visits to wards, informing us about things and making matters transparent in general… Why is it done? …justifications for that”.

Non-punitive responses to errors, learning and developing

Forensic nurses expressed a desire to muster the courage to talk about errors and learn from them in their organizations. According to them, there was still a prevalent culture of finding someone to blame and evaluating errors only after something had happened.

“We need to abolish the culture of finding the culprit and blaming them when an error occurs, and must learn what we can from our mistakes…”.

“… by searching for a solution to the problem of how to avoid a similar incident from being repeated”.

I think on the whole patient safety notifications are handled well in our hospital. However, “changes” often take place in situations “where the error has already occurred” instead of pre-emptively.
The forensic nurses also felt that steps were being taken to promote learning from errors and developing practices as a routine part of professional care, and a new culture of nursing was perceived to be forthcoming. In addition, there was evidence for an increasingly systemic approach to dealing with errors.

“...Maybe it will get clearer that the new culture of nursing is coming and leadership will probably change there on the side, too.”

Balancing staff and patient perspectives on safety culture

Forensic nurses noted that, traditionally, cultures that emphasize safety sometimes emphasize the safety of staff more than that of patients. More attention should thus be paid to patient-oriented work and interacting more closely with patients. However, as of the time of writing their responses, the nurses considered that patient safety and staff security were well balanced and that the safety of all parties was adequately accounted for.

“...patients have not been adequately planned for beforehand, and sometimes a patient has arrived in the rehabilitation ward in a highly questionable condition”.

“I think patient safety is given more attention these days. Previously, occupational safety came first, in which case the patient was perhaps left aside a bit... the situation’s pretty much evened out now, as it should be”. “In my opinion, patients should be given a chance to interact more closely with the staff...”

Some nurses felt that their leaders and managers don’t listen enough to their opinions, and that an increased focus on occupational safety and nurse motivation would increase both patient safety and the nurses’ working flexibility.
“...leadership could actually listen to and hear our opinions and views, after all, it’s us who are with patients here”.

“I think that patient safety also includes the occupational safety of staff and their motivation. An attitude of hospital management that supports and motivates staff would also increase patient safety and prevent excessive measures caused by burning out. Discussing and encouraging would probably make things function better and make nursing staff more willing to be flexible as well”.

Operational safety guidelines

The nurses stated that forensic patient care guidelines were somewhat unclear, and there was a desire to reduce the number of rules and to have clearer guidelines. They also wished for more collaboration in terms of negotiation between management and staff at the units when making decisions on issues regarding wards. It was suggested that this would increase the extent to which the views of staff are taken into account when evaluating how decided matters work on the wards (compared to the current approach based on one-sided orders from management) and thus influence nurses’ work in terms of patient care and safety.

“Guidelines from the house management are often unclear and contradictory, and there are so many of them that it is difficult to remember how each issue must be reported or which procedure must be used. The number of forms is excessive”.

“If the management makes decisions on issues regarding wards, it would be good to negotiate with the units on how the decided matter works in the wards in question instead of simply giving orders. This could improve cooperation for both parties and would allow us as practical workers to influence our work”.
Adequate human resources to ensure safety

The topic of staff shortages was also prominent in the forensic nurses’ written descriptions. Many nurses summarized their views on the level of staff resources and its impact on patient care. The fact that some hospital workers were unfamiliar with their patients was also identified as a factor that could hinder safe forensic patient care. These issues together or separately could create a risk of deviations in care.

“Patient safety is endangered by the shortage of staff resources – there is an attempt to take care of far too many difficult-to-treat patients with too few staff”…

At times, work is pretty hectic. For a while now, we’ve had a lot of temporary workers on the unit. In particular, at certain times we have to temporarily transfer staff from one unit to another.

Regarding the qualifications and competence of nursing personnel, the nurses pointed out that there was an increasing trend for staff positions to be occupied by people with higher academic qualifications.

“….the structure of staff positions has been changed to place more emphasis on academic qualifications.”

DISCUSSION

The study identified six themes, each of which reflects some respect in which patient safety culture could be developed and improved throughout the organization and in forensic nursing more generally. Our findings show that there are many aspects of patient safety culture that are common to and important in all healthcare contexts. However, issues relating to human resources and safety guidelines appear to be particularly important in forensic nursing.
The systematization of an open and trusting communication culture was seen as a central factor influencing patient safety. The communication culture in the wards was generally considered to be open but a couple of nurses described an atmosphere of fear in their wards that prevented open discussion. It has been noted previously that a dysfunctional communication culture can compromise patient safety. In addition, well-functioning communication has been identified as a core competency in mental health care. Psychiatric care and therapeutic relationships rely on the development of effective communication processes, and communication is also the key to de-escalation in psychiatric care. It therefore has a direct impact on patient care.

While the promotion of safety culture is not exclusively dependent on management activities, the forensic nurses strongly desired visible and close interaction between managers and staff. This is suggestive of a reactive culture in which safety systems are developed only in response to adverse events and/or regulatory requirements. Such a reactive culture could be reinforced by the trend identified by Vlayen et al., whereby clinicians occupying elevated positions in the institutional hierarchy have more positive safety culture perceptions than staff with lower positions in the hierarchy. This could increase the potential for misunderstandings between managers and staff.

The forensic nurses also wanted their managers to have up-to-date knowledge of the nurses’ working environment. Deficits in managers’ knowledge and skills threaten patient safety because managers play central roles in healthcare provision, being responsible for ensuring their staff’s competency and for identifying deficiencies and then remediating them through training and education. Management practices strongly influence how staff view patient safety, and interactions with nurses and their working environment increase managers’ understanding of nurses’ work.

The study’s findings confirmed the importance of non-punitive responses to errors, learning and developing. Our results showed that elements of a culture of blame were still present, and there was no systematic way of processing errors. However, leaders should view each error as an
opportunity for learning rather than seeing those who made mistakes as villains. Finding a balance between the extremes of punishment and blamelessness is the goal of developing a patient safety culture.\textsuperscript{34,35} The results presented herein are consistent with the findings of previous studies that have identified reactive cultures\textsuperscript{2,36} and suggested that the problems of such cultures can be addressed by learning from and preventing adverse events.\textsuperscript{37,38}

Another factor that emerged was the importance of balancing staff and patient perspectives on safety culture. This is important because increased patient involvement would improve the quality and safety of care, and is associated with positive health outcomes.\textsuperscript{39,40} Greater patient involvement would strengthen patient-doctor and patient-nurse relationships,\textsuperscript{41} promote patient-centered care,\textsuperscript{37, 42} and improve decision-making processes.\textsuperscript{43} Previous studies on patient safety have established that listening to and respecting patients and family members are crucial for effective therapeutic relationships.\textsuperscript{44,45}

Occupational safety and increasing staff motivation would increase also patient safety and staff’s flexibility regarding their work. Low nursing staff levels have previously been associated with lower safety culture scores.\textsuperscript{2, 46} However, it should be noted that different views on this issue have been presented: Kohn et al.\textsuperscript{47} argue that staff safety can be improved by attending to patient safety whereas Yassi & Hancock\textsuperscript{48} argue that patient safety can only be improved by attending to employee safety.

The respondents also highlighted the importance of operational safety guidelines in forensic psychiatric nursing. Nurse managers are responsible for standardizing processes, protocols, checklists and guidelines, establishing ethical protection for employees,\textsuperscript{49} and building a framework for cultural patient safety\textsuperscript{50}. From the perspective of nurse managers, the role of the organization is to create the basic infrastructure for ethical patient safety that respects human dignity.\textsuperscript{50, 51}

Vogelsmeier \textit{et al.}\textsuperscript{52} suggest the introduction of shared training for managers and staff, focusing on
mutual accountabilities regarding patient safety. A need for such training was also identified in this work.

Our findings are consistent with other studies regarding the need for *adequate human resources to ensure safety* in forensic psychiatric care. It has previously been shown that when the availability of attendants is sufficiently high nurses receive consistent support in providing high quality patient care and report increased job satisfaction, which reduces occupational burnout and staff turnover.\(^{53}\) It is impossible to determine the ideal number of employees in any given case without simultaneously looking at the quality of the work environment and workload,\(^{54}\) and patients’ need for care. However, it has been shown that workplace culture, especially the overarching factor of stress, correlates with the use of supplemental nursing staff and patients’ length of stay,\(^ {55}\) and also with the relationship between hospital system load and patient harm.\(^ {56}\)

**LIMITATIONS**

As noted above, this study has some limitations. First, it is based on data gathered via open-ended questions within a web-based questionnaire created for use in a larger study. Of the 238 respondents who completed the questionnaire, only 72 described their experiences and views on patient safety culture in their responses to the open-ended question. It is thus possible that the forensic psychiatric nurses who did not answer these questions may have had different perspectives. Each individual’s safety experiences are unique, and factors such as traumatic events or issues relating to the working environment may influence respondents’ answers.\(^ {57,58}\) However, the data were multifaceted and the forensic nurses’ descriptions complemented each other. Therefore, the research data were many-sided and suitable for qualitative analysis.

It should also be noted that further studies on a wider range of psychiatric care environments and larger populations would be required to generalize the conclusions presented herein concerning forensic psychiatric care, because cultures differ. However, this work provides a robust description
of forensic psychiatric nursing in Finland, and its results may be useful in enhancing safety performance in similar contexts in other countries.

CONCLUSIONS

This study underlines the importance of an open culture with open communication and protocols. On the basis of its results and the conclusions of earlier studies (e.g. Singer & Tucker59), we strongly recommended the adoption of patient safety walk rounds whereby managers spend time on the frontlines of care, discussing with staff and observing their work. Walk rounds are proven to be effective at strengthening safety culture.

It is essential to maintain an environment and culture that is safe for all patients and staff members. Further research is required to identify how to best bring about collaborative, effective teamwork (with both patients and staff) in forensic mental healthcare and to develop assessment tools for determining the level of human resources required to provide high quality patient care. In addition, there is a clear need to study patient safety from the perspectives of forensic patients because they experience the whole care path and can identify factors in their care that threaten patient safety.
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