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Metasynthesis of Research on the Role of Psychiatric Inpatient Nurses: What Is Important to Staff?

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Abstract

BACKGROUND: Inpatient psychiatric nurses are a large workforce, but their work is poorly articulated and thus poorly understood outside of the professional inpatient community. **OBJECTIVE:** To learn how inpatient psychiatric nurses depict their work, define important aspects of their role, and view the impact of the unit environment on their clinical practice. **DESIGN:** Metasynthesis of research that has focused on the ideas and perceptions of inpatient psychiatric nurses around their role and practice on inpatient psychiatric units. **RESULTS:** Three themes emerged from the analysis; the first was an umbrella for three important aspects of nursing work: the nurses' efforts to forge engagement with patients; their activities which maintained the safety of the unit and interventions nurses viewed as educating/empowering patients. The second theme captures the conditions that enabled nurses to do this work such as a cohesive nursing team and their sense of self-direction in their role. The final theme centers on difficulties nurses encountered in enacting their role which included multiple responsibilities for patient care and management of the milieu; intense work often with low visibility and scant support within the organization. **CONCLUSIONS:** Nurses need to articulate their practice so they can assert for the staffing and resources needed to keep units safe and promote patients' well-being, strive toward quality, and promote the development of the specialty.

Keywords

inpatient psychiatric nurses, inpatient psychiatric treatment, psychiatric hospitalization, qualitative metasynthesis

Inpatient psychiatric nurses are the largest professional workforce practicing on inpatient psychiatric units. Although nurses' work has been recognized as vital to the operation of the unit (Sharfstein, 2009) their expertise is often overlooked, misinterpreted, or minimized (Cleary, Hunt, Horsfall, & Deacon, 2011). One explanation for this seeming neglect is that nurses' work is poorly articulated in the professional literature (Fourie, McDonald, Connor, & Bartlett, 2005). Moreover since their work is entwined with the everyday functioning of a psychiatric unit it easily goes unnoticed (Cleary et al., 2011). Indeed, when a milieu team is working together and each nursing staff member is using their unique talents to care for patients the unit seems to run on its own accord. While such expertise in action is to be applauded, it is important to look beyond ingrained role behaviors and explicate the work of these nurses and the milieu staff.

On a fundamental level nursing staff's vital role in patient safety must be recognized so it can be maintained via adequate staffing in both numbers and nurse expertise (American Psychiatric Nurses Association, 2012). The work must also be acknowledged so that nursing staff is afforded organizational support to carry out the less visible aspects of their role such as engagement with patients. Nursing staff engagement with a person's experience is critical for hospitalized individuals who, by the very nature of admission criteria, are generally at a crisis stage of their illness (Barker, 2001). On a deeper level, engagement forges a connection critical to mental health recovery—a connection that is healing since it conveys a sense and appreciation of a person's human struggle (Spandler & Stickley, 2011). If the administration or the interdisciplinary team does not understand these aspects of nurses' inpatient role they are easily overlooked. With that disregard the interpersonal aspects of nursing are equally

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minimized. Finally being explicit about nurses' work is important so that novice psychiatric nurses are socialized into how everyday action connects to the purpose of treatment and the culture of the unit. Over the years, we have attempted to elucidate the psychiatric inpatient nursing role (Delaney, 1992; Delaney, Perraud, & Johnson, 2008; Delaney, Perraud, & Pitula, 2000; Johnson & Delaney, 2006; Johnson & Hauser 2001). Continuing this work we sought to learn how inpatient psychiatric nurses depict their work with patients and to that end reviewed the professional literature that has captured the voices of psychiatric nurses discussing their role.

Methodology

This article is a metasynthesis of the qualitative literature that details inpatient psychiatric nurses' perception of their role. Metasynthesis was considered appropriate to the intent of the review, which was to examine the themes in studies that were related to each other via their focus on a similar phenomenon. As Salmond (2012) points out, the goal of metasynthesis is cross-case generalizations; conclusions that do not equate to a form of external validity but generalizations that fit with or could be applied to other settings. In line with the aim of metasynthesis, the researchers integrated select qualitative studies by first breaking down the findings of individual studies, examining their key features, coding these features, and then combining the codes into categories that best explained the data and best represented all the cases (Salmond, 2012).

The metasynthesis was conducted in line with Cooper's five stages of research synthesis (Cooper, Harris, & Valentine, 2009). The process began with problem formulation (Cooper's Stage 1). The researchers were embarking on a larger project that would involve developing a tool that gauged how frequently nurses had experiences that promoted an environment conducive to patient-centered nursing practice. The literature contains individual studies on inpatient psychiatric nurses' views of their role and their thoughts around specific aspects of their role. However, there was no report of similarities across these studies that synthesized how PMH nurses depicted what was important to them about their work. A synthesis of the literature around this phenomenon was conducted to yield cross-case generalizations on this issue.

The literature search (Copper Stage 2) was conducted using CINAHL (Cumulative Index of Nursing and Allied Health Literature), PubMed (United States National Institutes of Health), and PsychINFO (American Psychological Association). Five search terms were used alone and in combination: inpatient nursing, inpatient psychiatric nurses, inpatient treatment, psychiatric hospitalization, and qualitative studies. The initial broad search yielded some 800 citations, which, based on title review and examination of abstracts, was narrowed to approximately 40 studies. Studies were selected that used qualitative methods to capture the work of inpatient psychiatric nurses and their viewpoints on their practice. Inclusion criteria for studies were the following: the intent of the research was clearly stated as was the methods used to gather and analyze the data, the participants and setting were described, and the results presented included nurses descriptions of their work on psychiatric units treating acutely ill patients. As is customary with integrative reviews of inpatient psychiatric nursing roles (e.g., Cleary, Hunt, Horsfall, & Deacon, 2012; McAndrew, Chambers, Nolan, Thomas, & Watts, 2013), investigations that were conducted on psychiatric units in Europe and Australia were included in the review. International comparisons on many aspects of inpatient psychiatric practice demonstrate similar issues and practices across national boundaries (e.g., Steinert et al., 2010).

Secondary analyses of inpatient nursing studies were excluded from the review (Cleary et al., 2011). From the initial pool of 40 research reports studies were excluded that targeted nurses work with specific types of patients (e.g., Latvala, Janhonen, & Moring, 2000) or specific patient behaviors (e.g., Carlén & Bengtsson, 2007; Gilje, Talseth, & Norberg, 2005). We also excluded studies that aimed to depict nursing expertise with particular safety issues such as dealing with aggression (Carlsson, Dahlberg, & Drew, 2000; Carlsson, Dahlberg, Ekebergh & Dahlberg, 2006; Johnson & Hauser, 2001). These studies described critical aspects of the nursing role, but we were focused on depictions of the work that nurses see themselves performing every day, their perceptions of these roles, and their elaboration of aspects of the work that they value.

The 16 studies published between 2000 and 2011 (see Table 1) that were included in the metasynthesis all employed qualitative methods to articulate the nurses' perceptions of their work on psychiatric inpatient units. One of the studies dealt with nursing work on an intensive care inpatient unit (Salzmann-Erikson, Lutzen, Ivarsson, & Eriksson, 2008) but as the authors suggest given the current acuity of patients on inpatient units the work described in this study is easily generalized to the broader psychiatric inpatient nursing role. One of the studies employed ethnomethodology and semistructured interviews to access a seemingly narrow area of practice, nurses' methods of empowerment (Lloyd, 2007). However since empowerment was tied to many aspects of nurses' work, the findings document nurses' perceptions of their role in a broader context.

Data were extracted (Cooper Stage 3) from primary sources if the information in the report was a reference by the nurse to his/her role or work on the unit. As explained by Whittemore and Knafl (2005) data extraction encompasses the data analysis phase since the researcher is both extracting data from primary sources as well as coding the data bits and then categorizing them into a scheme that

Table 1. Summary of Investigations of Inpatient Psychiatric Nurses Perceptions of Their Role.

Author	Study purpose	Methods/sample	Major findings
Berg and Hallberg (2000); Sweden	Examine PMH nurses' lived experiences of working in inpatient unit	Qualitative interviews, *N* = 21 nurses, mix of RN and LPNs, one nursing assistant (NA) on a ward in a general hospital ward	Relationship seen as foundation of work, built largely in everyday caring. Role involved handling unforeseen situations, struggled with independence and organizational barriers.
Bjorkdahl, Palmstierna, and Hansebo (2010); Sweden	Describe PMH nursing approaches with the context of demanding inpatient environments	Qualitative interviews, *N* = 19; 10 RN and 9 NAs from four wards in four different hospitals	Two different approaches emerged: a sensitive, perceptive one used to generate trust and signaling availability. One of force called when issues of safety and need for ward structure emerged.
Chandler (2008); USA	Describe nurses' experiences during a transition to trauma-informed care	Qualitative interviews, *N* = 10, 8 RNs and 2 administrators on one acute care unit in a community hospital	With trauma-informed care staff described a shift of control from staff to patient, collaborative relationships to manage symptoms.
Chiovitti (2008); Canada	Construct a grounded theory around nurses' caring role and meaning of caring	Qualitative interviews, *N* = 17 RNs in three urban acute psychiatric settings, two in general hospitals, one in psychiatric hospital	Caring was not a separate role but encompassing everything the nurse did in her day. The basic psychological concept of protective empowering was divided into two antecedent categories and four context categories.
Cleary (2003a, 2003b, 2004); Australia	Understand how nurses construct their practice in acute psychiatric units in light of changes brought by service reform	Participant observation, discussion groups, and qualitative interview, *N* = 10 RN, on one acute inpatient psychiatric unit	In three articles, nurses' perceptions discussed in terms of four themes: delivery of nursing care, relationships, power/control, overwork and professional attitudes. Nurses describe trying to hold on to therapeutic encounters in a culture of increasing demands.
Deacon, Warne, and McAndrew (2006); UK	Using a methodical analysis, develop a perspective on the work of nurses on acute psychiatric wards; what they actually do	Participant observation, listening to dialogues on unit, asking questions of nurses during course of work on two inpatient wards	Examined nurses' work within their data indicating the contextual realities of practice, particularly the responsibilities of the nurse and the ever-changing ward conditions. Findings include how nurses provide care in everyday activities and the relationships of both closeness and containment.
Delaney and Johnson (2006); USA	In process of understanding de-escalation skills, provides the ways nurses keep the unit safe	Participant observation, semistructured interviews with *N* = 16 staff (11 RNs and 5 MHWs) and *N* = 12 patients on acute inpatient psychiatric units	Describe nursing strategies to keep the unit safe including, being there with patients, become aware of behaviors, caring, and connecting, balancing the needs of the patient with unit conditions, maintaining patients' self-determination, active decision making on how to respond.
Fourie et al. (2005); New Zealand	Record range of nursing activities on inpatient psychiatric unit and gather perceptions of nurses about their role and then compare actual activities with perceived role	Nonparticipant observation, two focus group interviews with a total of *N* = 10 RNs on one acute inpatient psychiatric unit	Formulated a list of 10 inpatient nursing roles the researchers formulated and matched them with the nursing perceptions of work within those roles. Found broad agreement between role and nurses' sense of role but that the RNs operated with constraints of time, ward pace, and lack of control over practice.
Hall (2004); UK	Explore situation of nurses working in acute psychiatry in light of social/societal mechanisms that influence day to day care	Semi structured interviews with *N* = 5 RN on one acute psychiatric ward	Nurses described their work in terms of the milieu and also the interventions they drew on to both control behaviors and maintain vigilance. Within this context the nurses also endorsed the importance of the relationship. Issues of social control are discussed.
Hamilton and Manias (2007); Australia	How psychiatric nurses used observation in everyday assessments of patients, the embedded expertise of psychiatric nurses, and power relationships that shape nursing in this context	Participant observation, two focus groups and interviews with *N* = 13 RNs on one inpatient psychiatric unit, housed in a free-standing facility that was divided into two- 22-bed wards	Studies of inpatient nurses disregard the coercive mandate inherent in psychiatric profession. Data reveled how nurses scan the environment in various ways and also pick up on patient presentation. While this is seen as valuable to nursing work, it is often not seen as important to managers or others on the team. Observations demonstrate how nurses layer knowledge in their assessments.

(continued)

Table 1. (continued)

Author	Study purpose	Methods/sample	Major findings
Humble and Cross (2010); Australia	Gain understanding of why veteran psychiatric nurses remain in the field	Phenomenological interviews with *N* = 7 psychiatric nurses recruited on an inpatient psychiatric unit	Identified attributes that contribute to a psychiatric nurses' longevity in their role, including a sense of satisfaction with work, personal attributes that facilitate working with what may seem like a difficult population, a deep understanding of stigma, seeing advocacy as part of their role, and use of self.
Hummelvoll and Severinsson (2001); Norway	Describe the complexity of the working situation on inpatient units and how nurses balance ideals with work reality	Participant observation focused on nurses' working situation, *N* = 10 nurses were interviewed and 6 therapists/administrators on one- 12-bed inpatient unit	Describe how nurses aim to support clients in crisis with care related to the patients' suffering and experience but must cope with constantly changing conditions and the imperative of being ready to act. The nurses' humanistic approach was often held in balance with the demands of medical model treatment.
Lloyd (2007); UK	Describe nurses' perceptions of empowering practices and methods of empowerment	Ethnomethodology and semistructured interviews with 10 nurses on an acute admissions ward	Empowering practices in five areas were identified: working with mental illness, making connections with people, taking on the responsibility of the role, and working as a team.
Pitkanen, Hatonen, Kollanen, Kuosmanen, and Valimaki (2011); Finland	Explore nurses perceptions of what interventions they employed to support patients quality of life	Semistructured focus groups, ranging from 3 to 7 participants, total *N* = 29 nurses who practiced on seven adult acute units housed in two general hospitals	Five categories of interventions emerged related to care planning, empowerment, social and activating interventions, and security interventions. While on the face of it the interventions seemed standard, the nurses' elaborations provided important aspects to the context and interpersonal aim of interventions.
Salzmann-Erikson, Lutzen, Ivarsson, and Eriksson (2008); Sweden	Describe the care activities provided for patients on a psychiatric intensive care unit (PICU	Critical incident technique was used; observation and questionnaires completed by 18 nurses and nursing assistants followed by in-depth interviews with 5 of these individuals	Identification of core issues within the PICU unit involved dealing the initial situations that often involved dramatic admissions, treatment refusals, escalating behaviors, and temporary coercive measures. Within these contexts four nursing behaviors were identified including establishing boundaries, protecting, supporting and structuring.
Shattell, Andes, and Thomas (2008); USA	Explore the experiences of patients and nurses in an acute psychiatric unit	Phenomenological interviews with 10 patients and 9 nurses on a large (30 bed) inpatient adult psychiatric unit in a freestanding psychiatric hospital	Experiences of nurses were marked by pressure and chaos. Nurses yearned for therapeutic relationships with patients but found them difficult to achieve. Nurses perceptions of relationships were contrasted with patients' experiences.

both fits with and integrates the data. In this study, data were identified from a careful line-by-line examination of the content of the nurses' statements or authors' paraphrase of the nurse's statements. During this coding process categories began to form around engagement with patients, safety, as well as barriers to the carrying out what nurses considered essential aspects of their role. The relative emphasis on these roles varied. For instance, research that focused on intensive care units had less to say about broad role duties and placed greater emphasis on containment. While they contributed less to each of the evolving categories it was decided to include these data since they added richness to the nursing role of maintaining safety.

As categories (safety, engagement, and educating/empowering) began to form, data that seemed appropriate to a particular theme was placed in the category and then examined for fit with the category (Stage 3—Synthesis component). The first author conducted the primary data extraction and the codes and synthesis were reviewed by the second author. As pieces of data were placed within broad categories both authors examined if the data provided a information on differing aspects of empowerment/education, engagement or the process of maintaining safety, as well as the facilitators of the various role processes (Stage 4—Data analysis). The line-by-line coding, conceptualization of emerging codes, and then combining codes into categories followed the basics of the constant comparative method described by Miles and Huberman (1994). Cooper's final stage is data interpretation and then presentation of the findings. Based on careful examination of all the categories and the data they contained, three themes were isolated from the studies. The first theme concerned the focal question of the study: how nurses depicted the important aspects of their work. This theme has three components, engagement, maintaining safety, and educating/empowering patients. A second theme that emerged from our synthesis and analysis was particular conditions that enabled nurses to do this work. A third theme related to the difficulties nurses encountered in enacting their role, both the apparent demands of the work and the less obvious dichotomies—such as the pull between engagement and maintaining control of the unit. As the themes were elaborated the investigators constantly returned to the original sources to assure the data bit was being used in a manner that was consistent with its original meaning and context. In this presentation of the findings, each of these themes is elaborated based on nurses' comments from the 16 studies included in the review.

Results

Important Aspect of Work: Engagement

One prominent theme in these studies was the primacy of the nurse–patient relationship often depicted by nurses as the main focus of the role (Fourie et al., 2005; Humble & Cross, 2010). This relationship and partnership with patients brought purpose to nurses and their work (Cleary, 2003a). The nurses experienced the collaboration and engagement with patients as meaningful and professionally stimulating in and of itself not just as a means to a therapeutic end (Hummelvoll & Severinsson, 2001). Indeed interpersonal engagement brought with it a sense of shared humanity and within it nurses saw meaning in the experience of mental illness and meaning in the lived experiences they shared with patients (Humble & Cross, 2010).

This shared experience was engineered by using various interpersonal strategies, such as considering the situation from the patient's viewpoint or imaging how it would feel to be in crisis (Bjorkdahl et al., 2010; Cleary, 2003a) or specifically imagining the patient's situation (Chiovitti, 2008). At times nurses depicted the context of the relationship from the patient perspective, that is, nurses believed that via the relationship patients felt safe, understood, and supported (Hall, 2004). Nurses in Cleary's (2003a) study saw attunement and engagement as particularly important when unit tension was rising since it was through this understanding that nurses were able to effectively intervene in a manner consistent with the patient's preferences.

Caring and connecting with patients over small basic human needs, while seemingly embedded in the everydayness of the work, was also considered a critical bridge to the patient (Bjorkdahl et al., 2010; Delaney & Johnson, 2006; Lloyd, 2007). Meeting everyday needs goes beyond making rounds in the milieu and addressing surface behaviors or activities of daily living needs. Rather, gaining an appreciation for what the patient needed involved nurses intentionally setting out to "be there" for the patient (Berg & Hallberg, 2000; Cleary, 2003a) and taking advantage of any opportunity to engage patients (Fourie et al., 2005). Thus meeting patients' everyday needs proceeds from a rather complex process that involved attunement with the patient's affect, focusing on how the patient was expressing a need, and intentionally conveying the sense that the staff member was receptive to the person's message (Delaney & Johnson, 2006; Humble & Cross, 2010).

A related component of the relationship-building process involved developing a rapport with the patient. This involved conveying a respect for patients (Cleary, 2003a) as well as being accessible and "present" for the patients (Berg & Hallberg, 2000). Relationship building also involved elements of personal character. In the nurses' view interactions must be permeated with honesty and authenticity, which in turn entailed being consistent and genuine (Chiovitti, 2008). This relationship element was constructed on several well-recognized interaction skills: following the patient's lead (Chiovitti, 2008), being

empathic while maintaining a nonjudgmental attitude (Salzmann-Erikson et al., 2008), using one's self-skill base of listening (Humble & Cross, 2010), adopting an individualized flexible approach (Cleary, 2003a), and radiating feelings of warmth, consideration, and positive regard (Bjorkdahl et al., 2010). Although the demands of the work are great and inpatient staff members were often preoccupied with nonnursing tasks and paper work (Cleary, 2004; Hummelvoll & Severinsson, 2001; Shattell et al., 2008), when interviewers focused nurses on the relationship-building process participants were quite aware of its importance and the unique skills they used to engage with patients.

Engagement was also related to a fundamental aspect of psychiatric nursing, that is, supporting and helping patients by providing care related to their mental suffering and the crisis they were often experiencing (Hummelvoll & Severinsson, 2001). Here another aspect of the engagement process surfaces: within the relationship nurses seek to bring someone from the ravages of severe illness to positive health (Deacon et al., 2006). It is this work that makes the role fulfilling and brings significant satisfaction to nurses (Deacon et al., 2006). As expressed by one nurse:

> Within a few months of a major mental illness and you've helped them to sort out ways of getting back into the workforce, or getting back into socializing and communicating again with people, that the goal, for me, that's what it is all about. (Humble & Cross, 2010, p. 133)

Thus engagement ties into a larger purpose of psychiatric nursing; it provides the platform for supporting patients who are in acute crisis and helping them integrate the illness experiences and then as the hospitalization proceeds working with individuals to get back on track with their lives (Hummelvoll & Severinsson, 2001).

Important Aspect of Work: Maintaining Safety

Maintaining safety was a second dominant theme in the nurses' narratives of their work. Keeping a unit safe involves multiple interrelated behaviors. Of particular importance is maintaining a level of vigilance and awareness of an escalating situation and its potential to turn violent (Salzmann-Erikson et al., 2008). Maintaining readiness calls several behaviors into play such as developing a barometer for when the milieu might be breaching control (Delaney & Johnson, 2006) and an ability to quickly scan the unit and capture the social and physical conditions of the ward (Hamilton & Manias, 2007). As with many aspects of the nursing role there is a particular complexity to this seemingly straightforward behavior. For instance, vigilance involved not only watching but also reflecting on what was being observed. Reflecting involved reading and interpreting the situation (Hamilton & Manias, 2007). It was this "enriched observing" that enabled nurses to develop an understanding of the meaning of the behavior (Cleary, 2003a) that enhanced their ability to pattern behaviors and to compare the current presentation to what they knew about patients (Delaney & Johnson, 2006). This scanning and clinical observation helped nurses garner important clinical information that produced a tapestry of the patient: an understanding that allowed nurses to gain a level of knowledge about patients that was inaccessible to those outside of the nursing staff (Hamilton & Manias, 2007).

The observing function ushers in another vital component of this safety: anticipation and early intervention. Once again presence is part of the process, which in one study was manifest as staying aware of subtle changes and intervening as patients were getting upset (Delaney & Johnson, 2006). Interesting dichotomies surrounded this notion of being prepared to act but not acting. For instance, while the nursing staff maintained a vigilance, they often delayed an immediate response to a situation, mindful of the need to strike a balance between freedom and control (Hall, 2004). In some instances this involved ignoring threatening or intimidating behaviors, which required discerning which behaviors must be contained and which could be ignored or tolerated (Cleary, 2003a; Delaney & Johnson, 2006). While maintaining safety sometimes demanded imposing restrictions and controls (Salzmann-Erikson et al., 2008) nurses also sensed that protection must be balanced with empowerment (Chiovitti, 2008; Lloyd, 2007) and staff consideration of all available options prior to imposing restrictions (Chiovitti, 2008). In this decision-making process, nursing staff considered the impact of the patient's behavior, restrictiveness of interventions, patient rights, demands of staff, state of the unit, competing priorities, and whether restrictive interventions would make the situation better or worse (Cleary, 2003a; Delaney & Johnson, 2006).

Maintaining safety also called into play nurses' attitudes about aggression and conflict. Inpatient nurses believed their role required a degree of self-confidence (Humble & Cross, 2010) along with an acceptance of the unpredictable nature of the work (Cleary, 2004). Also critical were staff's attitudes and perceptions about verbal abuse or challenging behaviors, that is, it was mostly transient, should not be taken personally, and the behavior should be separated from the patient as a person (Cleary, 2003a; Salzmann-Erikson et al., 2008). In such instances nursing staff detached themselves from the situation and maintained a nonjudgmental stance (Salzmann-Erikson et al., 2008). Finally dealing with challenging situations called on staff's creativity and flexibility and on the art of being prepared to respond to strong, intense

situations with a calm, reflective, competent decision (Hummelvoll & Severinsson, 2001).

In one study, the unit culture had shifted toward a trauma-informed model of care (Bloom, 1997). In this context, nurses pointed out that prior to their culture shift maintaining safety involved the use of protocols to treat symptoms (such as self-harm) or the use of PRNs. They viewed this approach as "keeping patients safe in the face of limited resources" (Chandler, 2008). In contrast, nurses believed that in a trauma-informed model their safety provisions included use of diversionary activity, keeping a trauma history, and opening up a confined environment so there is space for relational connections, use of a safety tool; an array of evidence-based approaches where patients and staff work together to identify how staff can best support patient's safety (Chandler, 2008). Thus maintaining a safe unit is a complex task that calls on many aspects of the nursing role as well as qualities unique to the individual nurse.

One important aspect of maintaining safety was a staff team that worked together. Since nurses saw themselves as ultimately responsible for all patients throughout their shift teamwork afforded a feeling of "being in this together and a keen sense of relying on one another" (Deacon et al., 2006). Nurses often talked with colleagues when dealing with problematic situations they confronted (Cleary, 2003a; Lloyd, 2007). This consultation with the team was vital to maintaining safety since nurses became quite reliant on each other's impression of patients and trusted each others' judgments of risk (Fourie et al., 2005). Finally teamwork was a source of job satisfaction as working in a team resulted in a professional closeness with colleagues that nurses endorsed as a rewarding aspect of their role (Deacon et al., 2006).

Important Aspects of Work: Empowering and Educating Patients

Educating patients was also an important aspect of nurses' work and seen as fundamental to the role. Education was not depicted as a defined instructional session but rather as a process where nurses engaged in near constant dialogue with patients, families and students, giving (particularly families) the information they need to manage their experiences (Fourie et al., 2005). Education was tied to empowerment since the information gave patients choices and helped them build on capabilities and strengths (Chiovitti, 2008). Within this process, nurses also focused on helping patients identify the skills they needed to function in larger society (Chandler, 2008). Nurses also explained how education and the process of imparting information not only increased patients' understanding about treatment but also involved them in care (Cleary, 2003a).

Education interfaced and affected patient empowerment on several levels. Patient education was seen as a vehicle for decreasing the power differential between nurses and patients as well as helping patients retain a sense of control (Cleary, 2003a; Pitkanen et al., 2011). Along similar lines, nurses viewed joining with patients in the problem-solving process as a way to stimulate individuals to use their own resources for self-empowerment (Hummelvoll & Severinsson, 2001). This collaborative work and information-sharing helped nurses guide patients' awareness of what was critical for them to be able to cope with symptoms, manage relationships, and increase awareness of their environment (Chandler, 2008). What also accompanied this education process was a sense of working together on a task and accomplishing something meaningful to both patients and staff.

In his model of inpatient psychiatric nursing, Barkler (2001) explained how patients are admitted while in an acute stage of illness (and need *psychiatric nursing*). But then, as the crisis stabilized, patients needed information to help in community living (the skills of a *mental health nurse*). Nurses in several studies mirrored this idea and matched information with the patient's "stage of illness"—understanding what type of explanation is needed at what point in the patient's hospitalization (Cleary, 2003a). In Chiovitti's (2008) study, nurses viewed education as an incremental process but also an interactive relationship-based process where the patient was provided anticipatory guidance and feedback so that the individual had greater awareness of changes in his/her condition. As with safety and engagement, education/empowerment was embedded in the everyday work of nurses: captured in a fluid process that involved a deep knowing of the patient and sensitivity to what the patient needed at the moment.

Conditions That Support Engagement/Safety/Empowerment: Staff Attitude Around Rules

In most of the studies, nurses made time in their day and found opportunities for engagement with patients. However, in some instances institutional circumstances posed significant restrictions on the process (Cleary, 2004; Hummelvoll & Severinsson, 2001; Shattell et al., 2008). In one study, constraints on engagement arose from the unit structure, such as the rules and protocols around patient room time (Shattell et al., 2008). No doubt rules and protocols exist on all units, but in several studies nurses explained how, in the service of the relationship and responding to the patients' needs, they exercised latitude in interpreting rules (Chandler, 2008). Thus while inpatient units have a variety of rules and schedules there was a sense among respondents that these should be employed in the service of patient priorities.

Another attitude that promoted engagement/safety/empowerment was a conscious effort to reduce the distinctness of the role and adopt an unobtrusive, personal manner of interacting (Salzmann-Erikson et al., 2008). Cultivating this personal manner of interacting had several interconnected elements. One's attitudes around mental illness mattered. In this regard, nurses believed that it was important to diverge from the typical societal attitude toward mental illness, be curious about troubled minds but not see patients as different (Humble & Cross, 2010). Connecting to the basic human experience of the patient with acceptance and understanding was important and was demonstrated by one nurse in the "deep consideration he has given to the situation faced by those with mental illness" (Humble & Cross, 2010, p. 132). This theme mirrors a critical aspect of recovery, that is, seeing the patient as an individual and participating in a sense of shared humanity (Spandler & Stickley, 2011).

In discussing barriers and facilitating factors to engagement/safety/empowerment processes nurses again raised the importance of the team. The nursing team provided instrumental support by acting as a sounding board for staff talking about patients and their treatment (Chiovitti, 2008). Team sharing also provided nurses with the sense that one's work was appreciated by colleagues and staff (Hummelvoll & Severinsson, 2001). In fact, in Deacon et al.'s (2006) study, closeness with colleagues and patients was a major attraction of the role. Thus, while nurses faced many hurdles in the engagement/empowerment process (Shattell et al., 2008), they also developed attitudes around rules and used fellow staff to put themselves in a position to connect to patients.

Conditions That Support Engagement/Safety/Empowerment: Staff Self-Direction

To forge engagements, promote empowerment, and keep the unit safe, nurses used creativity along with their intuitive sense of the situation. These self-directed processes were most apparent in nurses' clinical decisions around particular unit situations. For instance, in determining how to intervene in an escalating situation nurses took into account how an intervention best addressed the situation (Delaney & Johnson, 2006). Salzmann-Erikson et al. (2008) provided an example of this process with a small vignette that depicted how a nurse established contact with a patient: "She made herself accessible for conversation by standing with a dishcloth in the kitchen door and letting the patient come to her instead of pushing the patient to interact" (p. 103). Here one sees nurses' use of imagination and patience but also how they shape interventions based on their "read" of the patient's signals (Bjorkdahl et al., 2010). This process entailed using intuition to get on the same wave length as the patient but also blending this intuitive sense with knowledge of the patients' life conditions and with the science of diagnosis and treatment (Chiovitti, 2008).

To maintain safety autonomy in decision making also came into play. In Cleary's (2004) investigation nurses clearly exercised self-direction in triaging and prioritizing intervention. This process was elaborated in another study:

> One nurse explained how she decided to deal with a patient who had spit on another patient. First, the nurse thought that the behavior was not typical for the patient. She also realized that several staff were dealing with another patient who was escalating so she did not have much backup should this incident escalate. The nurse also took into consideration her rapport with the patient, feeling fairly certain the patient would comply with what she requested. Two other factors came into play: One was the need for the patient who was spit on to feel safe, and the second was the need to separate the two patients. This example illustrates that while an intervention is occurring very quickly, the background thinking involved balancing multiple factors. (Delaney & Johnson, 2006, p. 203)

Here is effective crisis management in action, a practice that Deacon et al. (2006) viewed as the "very stuff" of inpatient nursing and provided nurses tremendous satisfaction in their role. In some instances effective crisis management meant responding in a paternalistic and (what might be considered) coercive fashion to maintain order (Bjorkdahl et al., 2010; Salzmann-Erikson et al., 2008). It seems contradictory that nurses employ both means (paternalistic and empowering approaches) to address issues of safety. On a broader level to assure smooth functioning of the wards integration of contrary means was part of the everyday work of nurses along with engagement to manage tense situations and the use of proactive measures to assure safety (Cleary, 2004).

Difficulties Encountered in Enacting Their Role: Strenuous Reality

Given all that nurses do in the service of enacting safety and promoting engagement it is not surprising that nurses felt responsible for the total ward environment (Deacon et al., 2006). For nurses that responsibility encompassed several roles: key facilitators of care, pivotal resource roles, coordinating care, and moving patients through the system (Fourie, 2005). Seeing that nurses are involved in so many aspects of the patient's lives (Humble & Cross, 2010), it is understandable that the inpatient nursing role has been depicted as a strenuous reality (Berg & Hallberg, 2000). It is not just the sheer number of role responsibilities. The strenuous reality is also generated from the energy required to enact these diverse roles, ranging from the mental activity required to interpret a patient's presentation (Berg & Hallberg, 2000) to the physical energy

demanded in tasks such as admissions and transfers (Cleary, 2003b). Circumstances inherent to inpatient treatment such as the chaotic and ever-changing nature of the ward demanded that nurses continually prioritize and integrate into their ongoing work the emerging issues that called for action (Deacon et al., 2006; Hummelvoll & Severinsson, 2001). Add the demands around communicating with all the professionals and outside agencies involved with the patient (Cleary, 2004) and one begins to understand why inpatient nursing has been depicted as a role with strenuous demands.

In one respect nurses were proud of the range of personal, administrative and time management skills required of the role (Humble & Cross, 2010). Yet nurses also said the numerous aspects of their roles carried taxing demands such as the need to be flexible in a wide variety of instances with a wide variety of patients (Berg & Hallberg, 2000) often amid a stream of refusals or treatment challenges (Salzmann-Erikson et al., 2008). Flexibility was also demanded to "weave together" activities that required very different skill sets such as going from leading a cognitive therapy session to assisting at serving a meal and then moving on to a patient who needed practical help such as completing an insurance claim (Deacon et al., 2006). Nurses also used "therapeutic dexterity and a repertoire of organizationally situated skills" to address an often rapidly changing patient population (Deacon et al., 2006, p.753). In the midst of dealing with a myriad of demands nurses also experienced a lack of organizational support, which seemed to result in less direction for treatment and diminished opportunity to influence care (Berg & Hallberg, 2000; Shattell et al., 2008).

Demands around treatment efficiency also contributed to the strenuous reality. The decreasing length of stay on U.S. psychiatric units is well documented (Stranges, Levit, Stocks, & Santora, (2011). Decreased length of stay raises the intensity of the ward (Hummelvoll & Severinsson, 2001) as well as the need to rapidly move patients through the system (Fourie et al., 2005). As these factors line up a picture of the inpatient nursing staff role began to form, one where staff were being pulled in many different directions to meet unrelenting, competing demands (Cleary, 2004; Shattell et al., 2008). With higher patient acuity, shorter length of stay and inpatient treatment oriented toward crisis stabilization, nurses worked to hold on to one-to one work, engagement activities, and a practice driven by the needs of the patient (Cleary, 2003a; Hummelvoll & Severinsson, 2001; Shattell et al., 2008).

Finally, a sense of a strenuous reality was generated when nurses experienced a lack of control in the work place that compromised care (Cleary, 2004; Shattell et al., 2008). To some extent, this lack of control arose from time-sapping nonnursing duties such as administrative concerns and excessive documentation (Cleary, 2003a; Fourie et al., 2005; Shattell et al., 2008). Poor staffing of the unit exacerbated the situation in subtle ways. When a unit was short of staff and temporary nurses were brought in not only did continuity of care suffer but permanent staff needed take over more responsibility (Fourie et al., 2005). Nurses also sensed a lack of control when they did not have the resources they needed to address situations, particularly overcrowding and the constant needs for beds (Hummelvoll & Severinsson, 2001).

Difficulties Encountered in Enacting Their Role: Managing Dichotomies

Particular dichotomies that are inherent to the nursing role (such as the split-focus between engagement and vigilance to safety) complicate role enactment. As Cleary (2003a) so eloquently stated, tension often exists between the role of therapy and the role of control. This balancing demanded sustained attention on possible escalations while at the same time not becoming rigid with rule setting (Delaney & Johnson, 2006; Hall, 2004). While control themes interspersed nurses' narratives veteran nurses were aware of the inherent power inequalities and strove to balance them and achieve harmony (Humble & Cross, 2010).

Nursing staff also managed the dichotomy between the clinical sophistication needed for dealing with seriously ill persons who present with a wide variety of illnesses (Berg & Hallberg, 2000) and the scant evidence-based therapy base to use when devising interventions (Bowers, Pithouse, & Hooten, 2013). One group of nurses related a subtle knowledge dichotomy between the information they needed to enact medical-model psychiatry and the type of information needed to understand the patient's suffering (Hummelvoll & Severinsson, 2001). From this uneven theoretical platform nurses believed that they needed to project confidence and competence in complex clinical situations, ones other health professionals tended to avoid such as handling crisis or protracted discussions with the family (Humble & Cross, 2010). An interesting dichotomy rested with equalizing the ideal in light of the reality of the milieu. As one staff group explained, inpatient nurses deal with the belief that, given the circumstances, the care they provided was questionable; yet simultaneously they feel pride in meeting the needs of patients in a flawed system (Cleary, 2004).

Nurses also dealt with the experience of carrying out intense work often with low visibility within the organization. This meant contending with administration's expectations of smooth unit operations along with their simultaneous disregard for nurses' knowledge, skills, and expertise (Cleary, 2004). The investigators suggested several underlying dynamics for why sophisticated skills become taken for granted by the larger organization. One, inpatient nursing interventions are difficult to measure and conceptualize (Cleary, 2004). Two, the pace of units acute care is chaotic and messy (Deacon et al., 2006).

Three, it may be that in the move toward evidence-based care the importance of a loving, caring, and containing relationship (work that occurs in the everydayness of activities) becomes lost (Deacon et al., 2006). Unfortunately, when critical elements of nursing practice are not made explicit the perception of inpatient nurses and nursing staff are shaped by the visible aspect of their role such as limit setting or tasks such as charting.

Discussion

Inpatient psychiatric nursing is in one stroke theoretically messy, highly practical, and clinically sophisticated. As the majority of nurses in the original studies recounted, they were artfully consumed with maintaining safety and deeply involved with engaging patients. Unfortunately it is a craft that remains relatively indiscernible to the world outside of psychiatric inpatient nurses. The uninformed observer might not detect this work for a variety of reasons but as the research demonstrated one contributing dynamic is that safety, engagement, and empowering education are ingrained in most every aspect of the staff role. Indeed, participants' narratives converged on how they exploited naturally occurring opportunities to engage with patients and most often communicated around individual's everyday needs. Contributing to the invisibility of the role is nurses' difficulty articulating what they do, a phenomena Deacon and colleagues attributed to the work being unformulated, "As it often involved the less tangible actions that demonstrate closeness and containing aspects of care" (Deacon et al., 2006, p. 753). However, imperceptible the work of nursing, staff clearly recognized they were vital to the smooth functioning of the unit.

An important theme that emerged from the investigations was the need for staff to maintain split levels of concern with one eye on the individual and one eye on the milieu. Several dichotomies arose from this dual focus and issues of empowerment often became threaded with issues of control. This circumstance demanded nurses constantly assess and balance the need for rules and order versus constraints on individual freedoms. As demonstrated by participants, accomplishing this task demanded expertise in tracking the state of the milieu while simultaneously being mindful of individual patient's state of mind. It also demanded contending with organizational constraints on practice and adequate staffing.

Taken together, these investigations provide a rare glimpse into the complexity of the inpatient nursing role. Since the studies in this review were published between 2000 and 2011, a consideration is the fit of these data with the current realities and roles of inpatient psychiatric nursing. One way to examine this question is to consider the key events affecting the inpatient nursing in the review time frame and consider if these factors have continued to affect inpatient nurses' work. A major impact on inpatient psychiatric nursing practice that occurred in the United States and Europe in the mid-1990s and continued into the next decade was an emphasis on restraint reduction (Busch & Shore, 2000; Stewart, Van der Merwe, Bowers, Simpson, & Jones, 2010). Restraint reduction efforts occurred in United States, Australia, and Europe brought on ideology shifts, increased regulation and governmental oversight (Steinert et al., 2010), and practice changes documented in the reports reviewed here, such as ways of keeping units safe without restrictive methods. A second trend, which also began in the late 1990s but carried forward throughout the decade were efforts to bring inpatient unit culture/practices in line with trauma-informed care (Bloom, 2010). In trauma-informed care, there is a greater awareness of the client's need for a particular environment; one study in this review (Chandler, 2008) reflects the impact of this culture change on nursing roles. The third factor that broadly affected psychiatric treatment in the mid-1990s was the recovery movement and its principles emphasizing hope, user self-direction, and collaboration (Hogan, 2003)—principles that slowly moved into psychiatric nursing practice in the past decade (O'Conner & Delaney, 2007).

The work of inpatient psychiatric nurses continues to be influenced by these factors. The efforts to reduce coercive measures, to instill a trauma-informed ideology, and adopt a recovery-oriented focus continue in present day inpatient psychiatric nursing (Beckett et al., 2013; Borckardt et al., 2011; Delaney & Johnson, 2012; Moller & McLoughlin, 2013; Muskett, 2014; Paterson, McIntosh, Wilkinson, McComish, & Smith, 2012). What has also remained constant are the basic goals of inpatient treatment, that is, keeping acutely ill patients safe, the type of patients admitted, and the reasons for admission (Bowers, Chaplin, Quirk, & Lelliott, 2009; Sharfstein, 2009). Interestingly, what patients seek from inpatient psychiatric nurses, engagement/caring and respect also persists in the present day (Gunasekara, Pentland, Rodgers, & Patterson, 2013) as does inpatient nurses' struggles with initiating these valued relationships in the complex arena of inpatient psychiatric treatment (Cleary et al., 2012). Thus, the need to investigate and understand the role of nursing on acute psychiatric environments, its nuances, rewards, and frustrations continues today much as it did in the first decade of the 21st century.

Limitations

Limitations include the small sample size of the studies used in the review and the range of study sites in both location and size. A potential bias is that well-functioning units may have been likely to respond to a researcher's request to study nursing practice. Only one researcher gathered both nurses' and patients' narratives; thus, it is unknown if nurses' perception of their engagement efforts

were perceived by patients in the same manner. Since the investigations in this review were conducted in on acute psychiatric units in Europe, Australia, and the United States, there may be regional differences in how the nursing role was actualized. Finally, since the studies date back to 2000 and span a period of 10 years, there are possible changes in inpatient nurses roles occurring since 2011 that are not accounted for.

Conclusion

Inpatient nurses quietly take on the responsibility for maintaining safety and providing care for individuals in an acute stage of illness and simultaneously take on the disrespect and criticism that has surrounds their work (Bournes & Milton, 2009; Cleary et al., 2011; Cleary et al., 2012; Deacon et al., 2006). It is time to move away from misperceptions about inpatient nursing staff. Nurses need a platform of credibility so that they can assert for the staffing and resources needed to keep units safe and promote patients' well-being (Cleary, 2004). Also, it will be difficult to promote the professional development of the specialty if psychiatric nurses continue to be regarded in ways that are subtly stigmatizing (Delaney, 2012). Misperceptions around nursing practice spawn a tight focus on achieving quality via restraint reduction, which, while vitally important, obscures issues that also constrain inpatient nurses efforts to achieve quality and safety, primarily providing them the resources they need to build trauma-informed environments and recovery-oriented cultures (Paterson et al., 2012). Finally, a tight focus on issues of coercion distracts from what should be the inpatient nursing agenda to improve care, such as greater family involvement; creating patient-centered, recovery-oriented environments; implementing meaningful programming; and involvement in the larger community to create effective care coordination.

Author Roles

The first author conducted the primary data extraction and the codes and synthesis were reviewed by the second author. As pieces of data were placed within broad categories both authors examined the data. Both authors contributed to the writing of the manuscript.

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