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Engagement as an Element of Safe Inpatient Psychiatric Environments

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Abstract

BACKGROUND: The American Psychiatric Nurses Association (APNA) Institute for Safe Environments (ISE) has focused on key elements that affect safety in psychiatric treatment environments; one of these key elements is patient engagement. An ISE workgroup discussed and reviewed the literature on engagement and safety in inpatient psychiatric settings. This article presents what we have learned about the role that engagement plays in inpatient treatment of severely mentally ill individuals and evidence that links nurse–patient engagement to safety. OBJECTIVES: To describe, using supporting literature, the role that nurse–patient engagement plays in creating safe, therapeutic environments for individuals with severe mental illness. DESIGN: (1) Define engagement and describe why it is an important element of safe treatment environments; (2) identify what helps and what hinders patients in their engagement with nurses, and nurses in their engagement with patients; (3) describe how engagement may improve unit safety; and (4) propose recommendations and set future directions for practice, research, and education. CONCLUSION: Engagement may provide the foundation for safe, therapeutic, and recovery-oriented treatment. In the future, APNA’s ISE plans to build upon this foundation by developing a clinical model of nurse–patient engagement and safety by drawing together emerging research and practice models.

Keywords
safety, engagement, nurse–patient relationships, inpatient psychiatric nursing, inpatient psychiatric treatment, inpatient hospitalization, recovery model

Introduction

Patient engagement is considered a critical element of maintaining safety on inpatient psychiatric units (Hamrin, Iennaco, & Olsen, 2009). The American Psychiatric Nurses Association (APNA) Institute for Safe Environments (ISE) has identified patient engagement as one of the key factors that affect the safety of inpatient environments. Although patient engagement is viewed as an important nursing performance measure (Pelletier & Stichler, 2013), there are scant research/practice data that clearly demonstrate the relationship between patient engagement and safety on inpatient psychiatric units. To develop the proposed connections between engagement and safety, this article will define engagement and describe why it is an important element of safe treatment environments. We will describe patients’ and nurses’ experiences of engagement from existing literature and identify what helps and what hinders nurses in their efforts to engage with patients, and patients in their efforts to engage with nurses. Finally, we will explore the relationship and interconnection between engagement and safety and then provide recommendations and future directions for practice, research, and education.

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What Is Engagement and Why Is It Important?

Engagement and safety are currently “hot topics” in health care, as well as in industry; a recent Internet search of those words produced over 380 million “hits.” Just a brief perusal of what is there demonstrates that the health care industry as a whole is trying to improve the experience of care, create cultures of safety, and promote the partnership experience between providers and patients. A Gallup poll with more than 350,000 respondents demonstrated that the leading factor influencing individuals’ engagement with their work was the employee’s relationship with his or her own direct manager (Adkins, 2015). Lipman (2013) notes that employees engagement in their work, or lack thereof, can have a direct impact on customer satisfaction and an organization’s “bottom line.” In the health care arena, the Agency for Healthcare Research and Quality has reported one way to prevent adverse events is to enable safety-oriented behaviors among patients (Weingart, 2013).

Engagement Defined

Broadly defined, engagement signifies being clinically involved with a patient while the patient moves towards clinical treatment goals. The term engagement is also used in the organizational literature to indicate a sense of engaging in one’s work to achieve a sense of fulfillment within the work environment. The literature on psychiatric-mental health (PMH) nurses and engagement uses the concept in both ways: as a clinical relationship with patients in direct patient care, and in an organizational sense as nurses’ engagement with their work environments. For PMH nurses the two definitions are interconnected, as active clinical engagement with patients is a critical component of commitment to their role in the work environment.

Clinically, engagement is an essential function for psychiatric nurses as they reach out to and connect, align, partner, and collaborate with people in order to help them. Engagement involves deliberate, meaningful interaction as a means for nurses to establish trusting, helpful relationships with patients. Engagement means “developing a trusting relationship between the treatment team and the individual” (Smith et al., 2010, p. 343).

Organizational engagement is defined as “an energetic state of involvement with personally fulfilling activities that enhance one’s sense of professional efficacy” (Maslach & Leiter, 2008, p. 498). Leiter and Maslach (1999) suggested six antecedents of engagement: workload, control, reward, community, fairness, and values. Although nursing engagement is still inadequately understood (Freeney & Tiernan, 2009), engagement in the work role has been the subject of several studies. For instance, Cho, Laschinger, and Wong (2006) found that engagement in work is related to an increased sense of empowerment and commitment to the organization. Engagement in one’s work role helps nurses avoid burnout, and provides nurses with a level of satisfaction, which is related to retention (Sawatzky & Enns, 2012). Engagement and work stress are also connected to the work environment, which for PMH nurses is influenced by staffing levels as well as managerial support for nurses’ work (Hanrahan, Aiken, McClaine, & Hanlon, 2010).

Importance of Engagement

There is research that supports the theoretical and practical aspects of engagement. In a longitudinal study of individuals with serious mental illness, Green et al. (2008) found that recovery was associated with the development of consistent relationships with providers who supported “normal” rather than “mentally ill” identities. Similarly, qualitative studies by Ware, Tugenberg, and Dickey (2004) and Angell and Mahoney (2007) reported that it is important for individuals who are in treatment to feel a sense of personal connectedness with providers. More recently, Delaney and Ferguson (2014) described how the development of trusting, open, and therapeutic nurse–patient relationships could build new neural connections in the brain that support essential functions such as emotional balance and response flexibility.

PMH nurses’ engagement in their roles also involves one-on-one engagement with patients. Engagement is facilitated when nurses are committed and dedicated, listen and encourage, and use a partnership model marked by problem solving and shared decision making (Gunasekara, Pentland, Rodgers, & Patterson, 2013; Smith et al., 2010). Engagement is also contingent on a genuine concern for the human condition and nurses’ use of their empathic skills. The process of engagement involves making a human–human connection and conveying acceptance, understanding, and tolerance (Cutcliffe & Barker, 2002; Eriksen, Arman, Davidson, Sundtor, & Karlsson, 2014). Smith et al. (2010) noted that strategies for enhancing engagement with clients could be implemented without any extraordinary commitment of resources. Basic elements are staff development and retention, such that a core group of committed staff populates the unit. Clinical supervision is also critical to nurses’ sustained engagement, along with continued education around the engagement process (Smith et al., 2010). Recently the emphasis on patient-centered care and patient activations has forged a new era of patients’ active engagements in their own health care, a process seen to rest on health literacy and interventions to support shared decision making, which in turn support active partnerships and improved outcomes (Carman...
et al., 2013; Sidani, 2008). That said, how do patients and nurses perceive engagement in inpatient psychiatric environments?

**Patients’ and Nurses’ Perspectives on Engagement**

*How Do Patients Experience Inpatient Nursing Care?*

A review of the literature revealed several themes that should be considered when proposing revisions to current inpatient nursing practice and delivery systems to promote engagement. Quantitative and qualitative studies indicate that positive outcomes and satisfaction with nursing related care inpatient care is multifaceted (Hackman et al., 2007; Livingston, Nijdam-Jones, Lapsley, Calderwood, & Brink, 2013; Ortiz & Schacht, 2012; Tambuyzer, Pieters, & Van Audenhove, 2011). When nurses are perceived as collaborative, engaging, caring, and knowledgeable and as spending quality time with people, a positive therapeutic relationship and inpatient experience may result (Mead & Bower, 2000; Shattell, McAllister, Hogan, & Thomas, 2006; Shattell, Starr, & Thomas, 2007). The atmosphere and physical structure of the unit must be conducive as a healing experience to foster a calm, peaceful, and safe environment. Thus patients’ perceptions of care, which provide important data on nursing interactions that are supportive, and types of relationships that are helpful, shape the elements and texture of the inpatient engagement process (McAndrew, Chambers, Nolan, Thomas, & Watts, 2013).

Themes of nursing care that patients considered as negative included inadequate nurse staffing levels, nurses not initiating communication or spending time interacting, nurses showing favoritism, nurses staying in the nurses’ station area, nurses laughing or joking about patients, nurses not listening, patients not being included in their treatment plan or educated on aspects of their care, and patients feeling judged and feeling that the milieu was unsafe (Gaillard, Shattell, & Thomas, 2009). The manner in which health care professionals interact with patients affects the level of participation and ultimately the outcome and satisfaction of care.

*How Do Nurses’ Experience Inpatient Care Settings?*

An organizational view of engagement is an approach that explores the relationship between staff engagement with their work and patient safety (Nahrgang, Morgeson, & Hofmann, 2011). Nursing staff engagement in their work is often measured via the Nurses Work Index–Revised (Aiken & Patrician, 2000). Here the quality of the practice environment and nurses’ engagement versus burnout is gauged and related to its impact on safety (e.g., Laschinger & Leiter, 2006). Hanrahan et al. (2010) found an enduring relationship between the work environment, managerial support, and nurses’ satisfaction with their work, which in turn influenced patient outcomes. These relationships of staff engagement and quality continue to be explored and elaborated particularly with regard to nursing outcomes (Van Bogaert, Clarke, Willems, & Mondelaers, 2012; Van Bogaert et al., 2013).

Staff engagement with patients and its impact on safety specifically has proven to be difficult to measure. The majority of research on nurses’ sense of engagement with patients is discussed in qualitative studies of nursing role/relationships (e.g., Andes & Shattell, 2006; Bridges et al., 2012; Cleary, Hunt, Horsfall, & Deacon, 2012; Shattell, Andes, & Thomas, 2008). As Cleary et al.’s (2012) review of 23 qualitative studies points out, nurses have developed communication styles and approaches to forge connections with patients: approaches that are quite sophisticated and fit well with the often challenging inpatient environment. Nurses have explained how they value engagement with patients and believe it is an essential connection to keeping units safe (Delaney & Johnson, 2014). The connection with patients provides both leverage and the type of “organic” knowledge that facilitates anticipation and proactive measures (Delaney & Johnson, 2006).

*What Hinders Engagement?*

We have discussed engagement as a concept for nurses in their direct care of patients and nurses’ engagement with their work environments and discussed nurses’ and patients’ experiences of nursing care and inpatient environments. Next we will describe what hinders engagement for patients and for nurses. Several elements of the sociocultural environment and individual factors may hinder engagement for patients. Individual factors that may limit engagement include denial of illness/insight, metacognitive deficits, and stigma from others and self (Lysaker et al., 2011; Smith, Easter, Pollock, Pope, & Wisdom, 2013; Tas, Brown, Aydemir, Brüne, & Lysaker, 2014). Aspects of inpatient care environment that may hinder engagement for nurses include vicarious traumatization; lack of training, supervision, and confidence; and violence, threats of violence, and fear (Van Sant & Patterson, 2013; Ward, 2013).

*Aspects That Hinder Engagement for Patients*

Denial of Illness/Insight. Engagement with patients can be challenging if clients deny they have a mental health problem and do not believe they require nursing interventions.
Engagement demands that nurses forge connections with patients by attuning to each individual’s affect and state of mind, and apperceiving the meanings of experiences as narrated by the person (Delaney & Ferguson, 2014). Forging such interpersonal alliances requires awareness that individuals dealing with mental distress may observe their illness and its impact in various ways. Engagement with a patient will be challenging if the patient denies he or she has a mental health problem and therefore refuses nursing intervention. This unawareness of illness or lack of “insight” (anosognosia), particularly in persons with schizophrenia, has been viewed as a function of neurocognitive deficits and symptoms rather than as a defensive response (Amador & Paul-Oduardi, 2000). Anosognosia (or impaired self-awareness; Prigatano, 2010) is also recognized in patients with depression (Startkstien, Berthier, Fedorof, Price, & Robinson, 1990) and those with dementia (Hanniesdottir & Morris, 2007; Startkstien, Jorge, Mizrahi, & Robinson, 2006), but clinical manifestations can vary widely from patient to patient (Cocchini, Beschin, & Della Sala, 2012).

Historically, issues relating to denial of illness by patients have centered on patients’ competency to refuse treatment (Roth et al., 1982) or give informed consent (Schachter Kleinman, Prendergast, Remington, & Schertzler, 1994). Clinically, we would anticipate a lack of engagement by the patient with the nurse if the patient is refusing treatment or has an impaired understanding of their treatment. Muskin et al. (1998) pointed out in a study using Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994) criteria in 1998 that 2.5% of psychiatric consultations involved maladaptive denial of psychiatric illness. This should be recognized and anticipated by PMH nurses as a potential barrier to effective engagement with patients.

Individuals may also not accept the full reality of their illness due to the discomfort they feel when considering the loss of their previous identity or wanting to avoid experiencing the grief and loss of a life not lived (Buck et al., 2013). Patients’ seeming “denial” is more accurately attributed to not wanting to feel the impact of the diagnosis that carries many negative connotations. Given these dynamics, nurses must approach the recovery journey with an individual by being respectful of their readiness to engage but also by suggesting ways to think about themselves and their future that may lead to a validated way of understanding their life story. Lysaker, Roe, and Buck (2010) depict this process as a way for individuals to arrive at enriched narratives and increased awareness of the loss and grief and next steps to restore hope and motivation.

**Metacognitive Deficits.** Some individuals with symptoms consistent with mental illness may not acknowledge aspects of the experience due to the metacognitive deficits that accompany the disorder, defined as difficulties associated with thinking about thinking, particularly the diminished capacity to form contextualized representations of self and others (Lysaker et al., 2014; Tas et al., 2014). These disruptions have wide-reaching impact on an individual’s sense of self across time and autobiographical memory. Nuanced methods to help individuals recognize feelings and think about thinking may help build metacognitive skills (Lysaker et al., 2011). Thus engagement with individuals dealing with agnosia, metacognitive deficits associated with the illness, or denial rooted in the perceived stigma attached to the diagnosis may require conversations in order to gain an in-depth understanding of the patient’s current perspective on his or her situation. These conversations can help the individual build a new set of stories to tell about himself or herself, particularly ones that depict him or her as meaningfully connected to others (Yanos, Roe, & Lysaker, 2011). These stories may begin to form the basis of a narrative, which is essential to a sense of self-cohesion.

**Stigma From Others and Self.** The phenomenon of stigma and psychiatric/mental health includes societal stereotypes leading to discrimination and a distancing between the individual and the protective factors that social groups provide (Corrigan & Rao, 2012). As a social species that relies on group acceptance for safety, perceived or actual exclusion from social groups does not allow for individuals in danger to call for and anticipate rescue (Bloom, 2010). The external influence of societal prejudice can become a contagion leading to self-stigmatization as a personal endorsement of those negative stereotypes. While stigma may not be well understood, treatment and recovery are effective only if that stigma is addressed as a primary barrier to engagement (Shrivastava, Johnston, & Bureau, 2012).

Self-stigma is a complex and paradoxical human experience (Lysaker, Roe, & Yanos, 2007) that can sway adherence to treatment (Fung, Tsang, & Corrigan, 2008) and that possibly affects the quality of motivation and readiness to participate in treatment and therapy (Goff, Hill, & Freudenreich, 2010). Each individual experiences the various forms of stigma from a unique perspective and only through engagement that effectively occurs between a patient and nurse can that unique context be understood and guide best therapeutic practice (Pandya, Bresee, Duckworth, Gay, & Fitzpatrick, 2011). Although there are strategies for combating stigma in clinical settings (Yanos et al., 2011) and in society in general (Clement et al., 2013), stigma and discrimination persist. Without the intentional implementation of compassionate relationships and evidence-based interventions, stigma may be unintentionally reinforced (Eriksen et al., 2014; Flanagan, Miller, & Davidson, 2009).
Aspects That Hinder Engagement for Nurses

Vicarious Traumatization. Several factors operating within psychiatric inpatient treatment have been identified as barriers to engagement, and stigma may be one of these hindrances to engagement with patients. If patients are viewed as dangerous or incompetent, then practitioner motivation to engage may be negatively affected. Caregivers must be willing to attempt to make a connection with each patient, regardless of his or her history. Institutions can set the stage for this expectation by crafting mission and vision statements that describe the importance of patient-centered care.

Another set of factors arises from the consequences of working closely with patients and then by identifying with their distress. For PMH nurses these negative aspects of engagement might be seeded in vicarious traumatization (Van Sant & Patterson, 2013). In these instances, PMH nurses may become overwhelmed by their efforts to work alongside patients (Sabo, 2011) or while working with patients who have suffered trauma, PMH nurses may themselves become traumatized (Collins & Long, 2003). Based on negative beliefs and implicit prejudices, nurses may avoid spending time with patients due to fears of injury or the possibility of further exposure to the trauma of others. Nurses may also experience states of hyperarousal or anxiety that mirror those of the trauma victims in their care—making it difficult to remain calm when dealing with patients who are in crisis (Zuzelo, Curran, & Zeserman, 2012).

Lack of Training, Supervision, and Confidence. In a recent APNA national meeting, the ISE convened an open forum. The participants identified several barriers to PMH nurses engagement with patients such as lack of training, inadequate clinical supervision, and narrow expectations of management around engagement. Lack of systematic training in engagement skills sends a powerful message about its importance. In addition, when time factors and unit acuity consistently trump staff development, staff engagement with patients is not viewed as supported. Clinical situations in which engagement is not encouraged contributes to a lack of confidence and to reluctance to involve oneself in engagement with patients, particularly if managers and administrators are not rigorously promoting and enforcing the use of engagement practices.

Violence, Threats of Violence, and Fear. Another serious barrier for PMH nurses initiating the engagement process is violence or threats of violence. Employees in the private sector suffer an injury rate of 2 per 10,000 employees, while nursing and personal care facility workers suffer an injury rate of 25 per 10,000 employees (Occupation Safety and Health Administration, 2004). In a U.K. study, 60% of PMH nurses reported experiencing violence or some type of aggression in the past year, 43% of which resulted in injury (Bowers et al., 2011). In Stagg’s (2013) multisite U.S. study, 3,193 assaults were reported, of which 1,305 (41%) resulted in injury. Such experiences of physical violence affect nurses’ mental health, stress level, and work productivity (Gates, Gillespie, & Succop, 2011).

Threat of violence also generates fear, which nurses have said they see as being “part of the job.” However, fear distracts nurses from patient care and often leads to miscommunication with patients (Ward, 2013). Nurses have reported that violence puts them on alert and influences their response to patients. They employ a variety of coping strategies to cope with violent encounters (Zuzelo et al., 2012).

A critical question remains: If the nurse–patient relationship is an effective tool for creating and maintaining a safe environment, then which comes first—the safe environment that fosters the nurse–patient relationship or the nurse–patient relationship that builds the safe environment?

What Facilitates Engagement?

An inpatient unit’s culture and model of care can be important facilitators for engagement. Approaches such as trauma-informed care (TIC)(Hopper, Bassuk, & Olivet, 2010; International Society for Traumatic Stress Studies, 2014;) model and the tidal model (Barker & Buchanan-Barker, 2010) emphasize active engagement with patients and describe nursing interventions required to achieve it. The tidal model is a holistic approach to care that promotes the exploration of patients’ narratives and encourages involvement in the decisions affecting patients’ assessment and treatment. In both the tidal and TIC models, the relationship is a mainstay of a safe and healing culture: a culture that must be created, and then maintained. While the tidal model has been used in the United Kingdom and Australia (e.g., O’Donovan, 2007), the TIC model has received wider adoption in the United States (Muskett, 2014), with emerging evidence that it has a positive impact on staff engagement (Borckardt et al., 2007; Chandler, 2008).

The TIC model creates a framework for developing a unit culture that prevents retraumatization and also creates a culture of engagement and therapeutic relationships. The model suggests that to establish a therapeutic alliance and engagement with persons who have experienced trauma, nurses must develop competence in understanding and addressing trauma. Effectively training staff in the model demands that staff be involved with and committed to the process of culture change (Harmon, Sey, Hiner, Faron, & McAdam, 2010).
Staff engagement can be fostered by inclusion in the development of nursing care delivery models and by leadership support for relationship-based care. Allen and Vitale-Nolen (2004) and Allen, Bockenhauer, Egan, and Kinnaird (2006) found that a relationship-based nursing care delivery model influenced work satisfaction and patient outcomes. In this model, nurses are expected to engage in frequent, respectful interactions with patients, with the purposeful intent to develop therapeutic relationships. Nurses are expected to reflect on their practice as a way of learning, and managers are expected to coach them in the use of reflective nursing processes that support empathy and self-awareness.

How Engagement and Safety Are Interconnected

The connection between engagement and safety is based on the assumption that safety on inpatient units involves both psychological and physical safety of patients and staff. In psychiatry, physical safety of patients is often framed in the context of restraint and seclusion and staff/patient injury. In this view, safety is grounded in methods to reduce rate of aggression and use of coercive containment methods (Bowers, 2014). In these efforts, staff engagement (e.g., staff’s emotional regulation, technical mastery) is a core component of the skill set that maintains a safe ward (Bowers et al., 2014). Early intervention into situations likely to escalate into aggression depends on staff engagement with patients: engagement nested within de-escalation techniques that include interpersonal skills such as empathy and respect (Bowers et al., 2013). Safety also demands staff skills to maintain a proactive approach to the milieu and to anticipate evolving events and use relationship leverage and engagement in order to effectively intervene in tense situations (Delaney & Johnson, 2006).

Safety on units also demands attention to patients’ psychological safety that may be vulnerable during inpatient treatment. When systematically queried, patients report they are often frightened on inpatient units and perceive the environment as volatile and threatening (Andes & Shattell, 2006; Frueh et al., 2005; Reddy & Spaulding, 2010; Stenhouse, 2013). Individuals have also reported that during hospitalization they frequently experience stigma, dehumanization, and humiliation (Lilja & Hellzen, 2008; Thibeault, Trudeau, d’Entremont, & Brown, 2010). Awareness of these phenomena and the role of trauma and mental illness support the development of trauma-informed cultures of inpatient care (National Center for Trauma-Informed Care, n.d.). Staff engagement with patients is a core component of these models, particularly forging avenues to understand the lived experience of individuals and via compassion and attunement creating dialogues whereby individuals feel comfortable sharing experiences (McAndrew et al., 2013).

Given the interdependence of engagement and psychological/physical safety, the work of psychiatric nurses is to assess staff’s sense of engagement with patients and patients’ sense that during interactions with staff they have been listened to, respected, and treated as an individual (Delaney, Johnson, & Fogg, 2015; Shattell et al., 2006). Psychiatric nurses should shape treatment cultures marked by these recovery-oriented, patient-centered qualities and then gauge their progress via patient perceptions of their treatment experiences. Engagement with patients should be a core skill, developed in novice nurses, and as the nurse’s experience grows, it should broaden to integrate sophisticated concepts around helping patients access narratives of their life experiences and building a cohesive sense of self.

Recommendations and Future Directions

As nursing care on inpatient units is multifaceted, the approach to define, promote, and investigate staff–patient engagement must also be multifaceted. A clinical model of patient engagement for PMH nursing is required and should be developed by the ISEs with the aim of promoting staff training, work cultures supportive of patient engagement and a research agenda that produces data demonstrating the relationship of patient engagement and safety. In this light, the APNA ISE has forwarded the following recommendations for education, practice, and research:

Support staff initiating and maintaining patient engagement

The ISE will provide resources on the APNA website on current knowledge and best practices of patient engagement. Psychiatric unit leaders, administrators, and managers should develop and support best practices to build a focus on patient engagement that would include training staff, delineating therapeutic care models, and increasing awareness of staff attributes that patients find valuable, such as approachability and kindness. Psychiatric nurse educators should build methods for competency training around relationship building. Psychiatric nurse administrators and managers should set patient engagement as part of yearly competency review and a staff member’s yearly performance evaluation.
Build healthy unit cultures and organizations that support patient engagement

Psychiatric nurse administrators and managers should publish exemplars of organizational mission and value statements, job descriptions, and policies that include accountability for engagement. Nurse researchers should examine work organizations and work roles that positively affect engagement and interaction with patients. The ISE will collect unit-based descriptions of how organizational approaches and particular unit cultures (e.g., trauma-informed care) support engagement. The ISE will gather and disseminate organization/inpatient psychiatric unit examples of successes and failures in clinical practices related to engagement and the transformation of organizational culture. In terms of regulatory policy, the Joint Commission should support engagement efforts by ensuring that a unit’s policies and procedures reflect patient involvement in their care.

Build a research agenda around patient engagement and safety

Patient engagement should be a component of a psychiatric unit’s outcome measurement system and reflected in patient satisfaction measures. The ISE will disseminate instruments to measure patient engagement and tools specific to inpatient treatment engagement. Administrators should develop standards for assessing safety from both staff’s and patients’ perspective as well as objective parameters of safety. Psychiatric nurse researchers should develop strategies to investigate the relationship of patient engagement and safety as well as identify strategies that enhance the engagement process and methods to measure them. Research should focus on identifying extrarelational factors that facilitate patient engagement such as unit design, particularly nursing station positioning.

Conclusion

In conclusion, the APNA ISE Steering Committee has proposed recommendations to (1) increase clinical practice support for nurses’ engagement efforts, (2) disseminate organizational models that support engagement, and (3) support research that will clarify how engagement is enacted on inpatient psychiatric units and the relationship between engagement and maintaining safety of inpatient environments. We anticipate this article will set directions for ISE’s continued efforts to clarify and operationalize this critical area of safety and inpatient nursing practice.

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