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Research Article

Safety Incidents in Psychiatric Inpatient Care: A Qualitative Content Analysis of Safety Incident Reports

Kaisa Mishina,[1] **Johanna Berg**,[2] **Veera Vainila**,[3] **Mikko Korte**,[3] **and Mari Lahti**[4]

[1]*Department of Child Psychiatry, Invest Research Flagship Center, Department of Nursing Science, University of Turku, Turku, Finland*
[2]*Turku University of Applied Sciences, Health and Well-being, Turku, Finland*
[3]*Turku University Hospital, Turku, Finland*
[4]*Turku University of Applied Sciences, Health and Well-being, Department of Nursing Science, University of Turku, Turku, Finland*

Correspondence should be addressed to Kaisa Mishina; kaisa.mishina@utu.fi

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Introduction. Safety is an essential factor in patient recovery, occupational well-being, and a well-functioning care environment. To identify and understand potential safety risks, information from safety incidents is needed. *Aim*. To describe safety incidents that occurred on psychiatric inpatient wards. *Method*. A retrospective register study. The data were collected from a web-based incident reporting database (HaiPro) from six Finnish psychiatric inpatient wards. The incident reports ($N = 76$) were analysed with descriptive statistics and inductive content analyses. *Results*. The incidents were verbally or physically aggressive situations, rule violations, or challenges in the ward's basic activities. The incidents resulted in consequences for patients, personnel, and the wards with varying severity. Some of the incidents could have possibly been prevented with simple, practical measures, such as sharing information, being prepared for safety practices, and having comprehensively planned care. *Discussion*. Safety incidents cause fear and challenges and could partly be prevented with multiprofessional and multilevel cooperation. *Implications for Practice*. Preventative actions include multidisciplinary and ward-specific education for safety practices, ensuring resources and not having too many patients on the ward. Multiprofessional communication and mutual understanding, including patient participation, are central. Wards should be designed or renovated so that safe environments can be guaranteed.

1. Introduction

A safe environment is an essential part of care. For patients, inpatient psychiatric care should provide a safe place where they are given the time and space to "simply be" [1]. Likewise, staff members need a safe work environment where they can concentrate on their core tasks [2]. However, safety incidents, i.e., harmful events with possible consequences [3], challenge these ideals. Safety incidents can be understood as situations that challenge the safety of patients or staff. The incidents can be "near miss" situations with a possibility to cause harm. This means incident which included a possibility for safety but did not realize in the current situation. The incidents can also be real adverse events that concretely happened and caused harm [4]. Safety incidents have multidimensional negative consequences on the well-being of patients and staff [5, 6] and on organizational operations [7]. To improve safety, it is important to learn about the causes of incidents and use this knowledge to develop systems of care [8]. Moreover, to ensure safety on psychiatric wards, methods for risk assessment and prevention of aggressive behaviour must be up-to-date.

Verbal and physical aggression toward health care staff is highly prevalent [9], and psychiatric care is one of the most at-risk places for occupational violence [10]. Compared to other specialty areas, psychiatric care involves a higher prevalence of aggressive incidents [11] and a higher level of both physical and nonphysical violence exposure [9]. In

addition, nurses have the highest prevalence to be exposed to violence across all other health care occupations [9]. Aggressive incidents can have severe psychological [12] or physical consequences [13], which are diverse and can include various aspects such as sleeping problems, fear, physical consequences, and material damage [14]. Care organizations can incur economic costs due to aggressive incidents, as those have a severe impact on invested time and related costs, such as due to the increased workload for staff members [7]. This means, for example, a high number of staff sick leaves, difficulties in recruiting capable and experienced professionals, and turnover intentions [15]. In fact, occupational violence in nursing care is a leading cause of job dissatisfaction, which contributes to absenteeism and turnover, and causes compromises in care [9].

In recent years, incident reporting systems have been developed and implemented in various fields of care in several countries [4] and are increasingly being used in health care settings [16]. These systems and measures are implemented with the aim of improving patient and staff safety by reporting adverse incidents and identifying and gaining understanding on safety risks in wards. The systems and real-time measurement approaches may also help staff anticipate and prevent aggressive situations and thus support staff in learning from the incidents, which can further lead to better aggression management skills as well as improving safety of care [17]. One example of such a system is HaiPro, a web-based patient safety incident reporting system widely used in health care settings in Finland [18]. HaiPro offers the possibility to systematically report safety incidents in health care setting [18], thus significantly improving patient safety culture [19].

Despite the current knowledge on safety incidents, there is a need to promote safety based on incident reports [16] and inpatient safety is an underresearched area although it poses unique challenges for patient safety [20]. Majority of the studies using incident reports from psychiatric care focus on quantitative perspectives, such as prevalence of incidents, which is certainly important. However, there is a need for qualitative studies to clarify more detailed explanations of aggression and how staff have experienced and positioned themselves to the situation [21]. In this study, we use qualitative and narrative perspectives based on nursing staff reports from a web-based incident reporting database. We investigated safety incidents that occurred in psychiatric inpatient wards from the nursing staff point of views. As aggression is a complex phenomenon, we wanted to gain a deeper understanding of the incidents; the focus is on narrative descriptions of the events. This knowledge can further assist the development of procedures of practice and new interventions to improve safety in psychiatric inpatient care.

2. Materials and Methods

2.1. Design and Ethics. This is a retrospective register study using safety incident reports collected through the HaiPro reporting system and analysed with content analysis to explore safety incidents that occurred in psychiatric inpatient care in Finland. The study was conducted according to the guidelines of the Declaration of Helsinki and was approved by the Ethics Committee at the Hospital District of Southwest Finland (Statement ETMK 128/2018). Permission to conduct the study was received from the hospital authorities. The study is reported in line with the CASP Qualitative Studies Checklist [22].

The safety incident reports were anonymous and with no information which could identify the patient or the nurse. Therefore, there were no identifiable data or of patients or of those submitting the report. As these reports can be seen as register data, there has not been asked personal consent. In addition, in qualitative analyses, the reports were analysed in pooled form, not per ward. With this, identification of patients, a certain nurse, or ward was avoided.

2.2. Data Collection. The data comprised all safety incidents ($N = 76$) reported through the HaiPro incident reporting system by personnel on six psychiatric wards in one psychiatric hospital district in Finland between March and August 2019. The district is a public organization, consisting of nearly 30 member municipalities with a total of over 470,000 residents. The participating wards specialized in different areas and included three psychoses wards, an addiction psychiatric ward, a geriatric psychiatric ward, and an adolescent psychiatric ward.

2.2.1. Safety Incident Reports. Systematic reporting of the safety incidents was conducted on the wards. A postincident report was performed routinely after every incident. Personnel reported all patient safety incidents, occupational safety incidents, and security incidents through the web-based HaiPro system on the hospitals' intranet. A narrative description of each incident was written as part of the report. The incident reports included the date, time, and place of the incident, the type of incident, involved patients' numbers, the targets of violence, the forms of violence, measures taken to stop the incident, the consequences to the target of violence, and the consequences to the ward.

2.3. Analysis. The written descriptions of three key areas are as follows: (i) what happened during the safety incident, (ii) consequences of the safety incident, and (iii) how the safety incident could be prevented in future. These were analysed with inductive content analysis [23] by searching for similarities and differences in the data. First, the meaning units were selected, and the text was coded and assigned to the units. Second, the meaning units were grouped based on similarities and differences, and these groups were named. Third, the codes were divided into subthemes and named. Fourth, the named subthemes were compared and grouped based on similarities and differences. This finally formed the themes, which were named as content characteristics. The analysis was performed by one author, but the themes were discussed with the other authors. The quantitative data were analysed with descriptive statistics using SPSS Statistics, version 21.0 for Windows 25. The data analysis process is exemplified in Table 1.

Table 1: Examples of meaning units and codes in the data analysis process.

Authentic expressions	Codes	Subcategories	Categories	Main categories
"*In their own room tried to hurt themselves by cutting with paper and by strangling with a charger's wire*." [ID 12]	Patient was self-harming	Patient was dangerous toward themselves	Aggression toward others or themselves	What happened at the safety incident
"*Emotional coping of the nurses is really low*." [ID 69]	Nurses were exhausted	Increased emotional distress	Decreased health and well-being	Harmful consequences for personnel
"*Patient was manually restrained by two nurses and a third nurse was called for help to secure the situation*." [ID 64]	Manual restraint by multiple nurses	Manual restraint	Use of coercive measures	Possible consequences for patients
"*Patient was manually restrained and taken to seclusion and given medication*." [ID 75]	Patient was taken into the seclusion room	Seclusion		
"*Patient was informed that they would be discharged from the ward after having Suboxone. The patient was also told that a guard or the police would be called if the patient acted aggressively toward others*." [ID 76]	Patient was discharged from the hospital after a substitution medication was given	Patient was discharged from the hospital	Changes in planned treatment and care	

Table 2: Characteristics of the safety incidents ($N = 76$).

Characteristics	Number of patients and staff in the units (n = patients/staff)	Patient safety incidents ($n = 20$)	Occupational safety incidents ($n = 41$)	Both types of safety incidents ($n = 15$)
Unit n (%)				
Three psychosis wards	48/62	12 (60)	18 (44)	8 (53)
Addiction psychiatric ward	12/17	0 (0)	3 (7)	4 (27)
Geriatric psychiatric ward	18/24	5 (25)	11 (27)	1 (7)
Adolescent psychiatric ward	10/22	3 (15)	9 (22)	2 (13)
Type of incident n (%)				
Violence		20 (100)	*n*/a	12 (80)
Other		0 (0)	*n*/a	3 (20)
Time of incident n (%)				
Morning 7 am–12 pm		2 (10)	6 (15)	2 (13)
Daytime 12.05 pm–17 pm		4 (20)	6 (15)	2 (13)
Evening 17.05 pm–11 pm		5 (25)	15 (37)	7 (47)
Night time 11.05 pm–6.59 am		5 (25)	12 (29)	4 (27)
Day of incident n (%)				
Weekday		12 (60)	28 (68)	11 (73)
Weekend		8 (40)	12 (29)	4 (27)
Place of incident n (%)				
Corridor		4 (20)	8 (20)	3 (20)
Patient room		4 (20)	12 (29)	2 (13)
Day room		4 (20)	4 (10)	5 (33)
Seclusion room		1 (5)	6 (15)	2 (13)
Reception room		0 (0)	0 (0)	1 (7)
Toilet or washroom		3 (15)	1 (2)	1 (7)
Patient's home		1 (5)	0 (0)	0 (0)
Office		1 (5)	3 (7)	0 (0)
Other or not mentioned		2 (10)	7 (17)	1 (7)

Table 3: What happened during the safety incident?

Subcategories	Categories	Main categories
Patient tried to hurt a nurse		
Patient attacked a nurse		
Patient tried to hit a nurse		
Patient acted aggressively toward the nursing staff	Patient was aggressive toward nursing staff	
Patient verbally threatened the nursing staff		
Patient aggressively resisted treatment activities		
Patient locked a nurse into a small space and acted aggressively		
Patient was threatening in the seclusion room		
Patient had a sharp object		Aggression toward others
Patient was threatening after restricting actions		
Patient was agitated and threatening	Patient acted threateningly	
Multiple patients disturbed the ward together		
Patient raged on the ward		
Patient went without permission to the ward's kitchen		
Patient's relative verbally threatened the nursing staff	Patient's relative was aggressive toward nursing staff	
Patient attacked another patient	Patient was aggressive toward other patient	
Patient was angry and verbally aggressive toward other patient		
Patient was self-harming		
Patients was suicidal		
Patient took an overdose of medicine	Patient was dangerous toward themselves	Harming themselves
Patient moved so restlessly that they nearly fell		
Patient tried to run away from the ward		
Patient had illegal substances		
Patient had needles and syringes for drug use	Drugs or needles were found on the ward	
Patient had used illegal substances in the ward		
Hospital's alarm system was not working		
The psychiatrist on-call could not be reached		Safety issues on the wards
Too many patients in the ward	Challenges in hospital's basic activities	
The instructed amount of (male) nurses is not met		
Injuries when training physical restraint techniques		

3. Results

3.1. Characteristics of the Safety Incidents. A total of 76 safety incidents were reported during the six-month study period. Of those, 20 were patient safety incidents, 41 were occupational safety incidents, and 15 included both types of incidents. The incidents were mainly reported by registered nurses ($n = 56$, 74%), followed by practical nurses and other health care professionals ($n = 20$, 26%), including mental health nurses, public health nurses, and nursing students. The incidents were mostly related to violence and occurred especially during evenings and at night. For more detailed descriptions of the safety incidents, see Table 2.

3.2. First Key Area: What Happened in the Safety Incident. The safety incidents were related to three types of situations (Table 3). First, situations where the patients or their relatives were verbally or physically aggressive toward staff or other patients, second, situations where patients were harming themselves, and third, situations due to safety issues in the wards, including illegal substances found or used in the ward and challenges with safety in basic ward activities.

Patient aggression occurred verbally and physically. Nursing staff were verbally threatened with violence during the event or in situations afterwards, for example, if the involved parties met later outside the hospital. In some cases, a patient's relative verbally threatened the nursing staff when they were dissatisfied with treatment. Patient aggression also occurred as physical violence, such as hitting, kicking, and shoving. Some incidents occurred without any warning signs, for example, during a neutral encounter between patients and staff in the corridor. Incidents also occurred in care situations, for example, when a patient aggressively resisted treatment. On one occasion, a patient locked a nurse in a patient's room and then attacked the nurse.

> *When the nurse came out from the patient's room, another patient was holding the door and did not let the nurse come out. After the nurse was able to push the door open, the patient attacked the nurse and hit their face with fists.* [ID 59]

Patients' frustration or anger was interpreted as threating behaviour, especially when their actions were restricted. Sometimes their aggression was focused on other patients. Threating actions were carried out either by a single patient or multiple patients together. Sometimes, a group of patients caused a threating environment for the whole ward.

> *Three adolescents were in their room rioting, e.g., spreading toilet paper all around the room and shouting disturbingly at other patients. They closed the door, not letting others enter the room. The door was broken when it was opened with force.* [ID 51]

Safety incidents were also related to cases where a patient was intentionally or unintentionally dangerous toward themselves. Unintentional self-harm included, for example, uncontrollable moving with a risk of falling. Intentional self-harm was related to incidents where a patient attempted to run away from the ward or tried to hurt themselves.

> *The patient was under close observation. Went to toilet and locked the door. Did not answer and therefore staff went inside using a key. The patient had wrapped a laundry bag string around their neck trying to strangle themselves. This was noticed early enough, and the patient was raised up and was then woken up. The patient was guided to their own room and close observation continued. The MD in charge was called, no further actions for this matter.* [ID 26]

The incidents, not related to aggression, resulted from challenges in the hospital's functions and individuals' intentional or unintentional actions. In some cases, the incidents were due to challenges in basic activities of the hospital, such as not having enough nursing staff on a shift or having too many patients in a ward. This meant the situations when the number of patients exceeded the number of beds in the ward. Sometimes, illegal substances were found in a ward or a patient had clearly used some kind of substance.

> *The patient was in voluntary treatment on the ward and came to return drug injection equipment, which they said was "found" at the back of the ward under board games. The equipment contained fresh blood. A few patient rooms were checked, the patients who had arrived most recently and the one who returned the equipment. No findings. After this, a few voluntary treatment patients were semi-randomly asked aside to check for possible injection marks on the skin. No findings.* [ID 5]

3.3. Second Key Area: Consequences of the Safety Incidents. The safety incidents caused consequences for patients, personnel, and wards (Table 4). The severity of the consequences varied from not severe, such as difficulties in conducting working tasks normally, to more severe, such as injuries or even possible death.

Consequences for patients mainly affected those involved in the safety incidents, but there were harms for other patients as well. In the incidents related to aggression, the consequences were often some kind of restrictive measure: from being put in a comfort room at the mildest to a more restrictive mechanical or manual restraint. Sometimes changes had to be made in treatment plans, for example, when certain care actions such as washing were not possible to carry out. For patients in voluntary treatment, the consequence for aggressive behaviour or possession of substances on the ward was often to be discharged from the hospital. Besides those involved in the incidents being affected, other patients also suffered physical and emotional harm.

> *The patient who was the target had a red mark on their neck.* [ID 25]

Table 4: Consequences of the safety incidents.

Subcategories	Categories	Main categories
No consequences or harm to other patients No consequences or harm to the patients themselves	No reported harms	Consequences for patients
Possibility for serious injuries Minor physical injuries Probable death	Physical harms	
Manual restraint Seclusion Mechanical restraint Comfort room Additional or forced medication Constant observation	Use of coercive measures	
Patient is discharged from the hospital Treatment measures cannot be performed Patient was sent to emergency ward	Changes in planned treatment and care	
Another patient's condition gets worse Endangered safety of other patients Other patients are scared Small physical injury to the other patient	Harms other patients	
Challenges for working arrangements Endangers working environment Extra works due to safety incidents Being involved in potentially dangerous situations	Decreased occupational safety	Harmful consequences for personnel
Increased physical distress Increased emotional distress Receive physical injuries	Decreased health and well-being	
Being the target of actual physical violence Being the target of attempted physical aggression	Physical violence	
Being verbally insulted Being verbally threatened of violence Patient's relative verbally threatens	Verbal threats and insults	
Calling additional nursing staff to work Need for help from nursing staff from other units Consulted medical staff Need for outside resources	Need for additional resources	Operational difficulties for wards
Impossibility to be present for other patients Disturbs constant observation of other patients	Difficulties in caring for other patients	

> *There were no injuries to the patient who was the target of scissor throwing. In general, this aggressive patient causes worry and fear among other patients.* [ID 4]

> *Each patient suffers in their own way from the possibility that aggressive situations will occur.* [ID 18]

Consequences for personnel were immediate, for example, when they were the target of physical violence, or after a while, when there were decreased occupational safety measures.

> *Difficult-to-treat adolescents on the ward. Of those, three are under close observation and many manual and physical restraints as well. Nurses working in close observation often work alone, e.g., manually restraining an adolescent who is suicidal or intends to move (those with an eating disorder). Female nurses especially suffer from physical stress when manually restraining a patient.* [ID 69]

> *Nurses are emotionally exhausted because the nurses have been asked adequate medication for the particular patient. The patient's behaviour is dangerous and unpredictable, causing worry and fear among nurses. In addition, patient safety and occupational safety are notably endangered.* [ID 4]

Operational difficulties for the ward included the need for additional resources and difficulties performing treatment and care. Additional resources meant extra nursing staff, calling medical staff, or asking security guards to ensure the safety of the situation. Basic ward tasks were endangered by safety incidents. This meant challenges in treating and being present for other patients and in taking care of everyday activities.

> *Mandatory work, e.g., close observation, supportive discussions, evening meal offering, and reporting were not possible to conduct.* [ID 50

3.4. Third Key Area: Possibilities to Prevent Safety Incidents. The prevention of safety incidents included sharing information about the occurred incidents, being prepared for safety practices, and comprehensively planned care (Table 5).

Table 5: Preventing safety incidents.

Subcategories	Categories	Main categories
Informal discussions between staff	Discussions about the safety incident	Information regarding occurred safety incidents
Discussing the incident with the patient		
Going through the incident during the ward meeting		
Informing management about the incident	Reporting the safety incident	
Careful recording of the incident		
Conducting a formal reporting process		
Renovating wards to ensure a safe environment	Sufficient environment and resources	Preparedness for safety practices
Ensuring a sufficient amount of human resources		
Ensuring the amount of male nurses		
Enough training on safety practices	Having enough knowledge regarding safety practices	
Having enough education about disorders		
Regular reminders about safety practices		
Clear instructions how to ensure safe nursing care		
No possibilities to prevent the safety incident	Some safety incidents cannot be prevented	
Ensuring workable multiprofessional cooperation	Operating as a workable team	Comprehensively planned care
Good cooperation between wards		
Nurses having possibilities to influence to care		
Systematic utilization of safety practices	Clear and well-planned everyday care	
Sufficient regular and as needed medication for patients		
Carefully planned preventative methods		
Planning nursing care tasks in advance		
Considering possible conflicts between patients	Considering the suitability and amount of patients to be treated on the ward	
Enabling patients to transfer to the correct treatment facility		
Not having too many patients on the ward		
Balance between resources and patients' conditions		

Formal and informal discussions with involved patients, the whole nursing staff, and management were seen as important, as was the thorough reporting of safety incidents. In many cases, ward meetings were mentioned as central channels of discussion about the incidents between the staff.

> *The incident will be gone through with staff in the next ward meeting.* [ID 2]

> *Discussing among staff whether there are some ways to prevent this type of situation in the future.* [ID 12]

Good preparedness for possible safety incidents meant that practices and resources are organized corresponding to the needs, i.e., that staff would have sufficient knowledge and safety training would be offered regularly. Sometimes, the physical environment of the ward was not sufficient for treating patients. There were toilet rooms where patients could lock themselves or staff in and windows that were normal glass. The latter were marked to be changed to nonbreakable materials to prevent patients from breaking the windows and harming themselves or others. Beyond the environment, routine safety practices were seen as central in preventing incidents. Furthermore, a safe environment requires a balance between the number of patients, their condition, and staff resources.

> *To ensure the safety of the nurses, two close observations need to be guaranteed sensitively. Going through the safety practices.* [ID 24]

Comprehensively planned care meant that the staff worked as team with good cooperation, preferably with a multiprofessional team, where also nurses have possibilities to influence treatment and ward practices. Everyday care should also be planned beforehand so that everyone knows their duties and tasks are not left undone.

> *There are too many violent and unpredictable patients in the ward. The number of patients should be decreased.* [ID 19]

4. Discussion

This paper describes safety incidents that occurred in inpatient psychiatric care. The reports from the staff were included, focusing especially on their narrative descriptions concerning the incidents. This study fulfills the current knowledge by pointing out staff interpretation when they construct explanations of safety incidents and position themselves to the incidents. The results indicate that safety incidents decrease the well-being of patients and nursing staff and cause challenges for organizations. Some simple and practical actions for the prevention of safety incidents were suggested. This included good communication, workable cooperation, sufficient preparedness, and comprehensively planned care procedures.

Nursing staff described that safety incidents worsened their physical and mental well-being. Several studies have reported similar results with increased turnovers and sick leaves due to occupational violence [9, 14]. In turn, stress and excessive workload can be also an issue that challenges patient safety, as nursing care suffers because of the lack of personnel, for example [24]. This was also seen in this study and staff members reported how they do not have enough time for patients. This can further cause the feelings of irritability, tension, and tiredness [24]. Thus, preventative actions and strategies are urgently needed [9], taking into account that safety incidents caused harm to patients as well, individually and collectively because of the ward's atmosphere.

It is not only patients' actions that challenge the safety of wards. Some safety incidents were related to operational difficulties, such as lack of resources and having too many patients in the wards. The importance of the balance between resources, the amount, and type of patients has been highlighted, and lack of resources may cause a risk for patient safety [24]. Resourcing of services is one of the central aspects of safety issues in mental health care [21]. An underresourced system greatly increases the risk of burnout in staff because of emotional exhaustion, detachment, and poor mental health [25] which can further lead to poor care.

Comprehensively planned care including workable multiprofessional cooperation and well-planned daily care were considered important in our data. In fact, it seems that these are fundamental factors in any care environment. For example, a systematic review conducted in the emergency department highlighted the importance of a well-planned care process and effective interprofessional communication and collaboration [26]. The importance of communication was found also in another systematic review pointing out that poor communication can damage safety and cause, for example, medication errors [27]. Some challenges in teamwork between nursing staff and medical doctors have been reported previously [24] and similar was recorded here related especially to treatment decision-making. Nursing staff have typically a good insight about the patient's situation. Therefore, it is important that their professional skills and experiences would be taken into account, for example, in treatment decisions. When asking inpatients about their feelings of safety, predictable treatment and care processes and a friendly ward climate with supportive routines were mentioned [14]. These are quite similar to the staff's perspectives. Therefore, well-planned care and predictability can be seen as central in creating a safe care environment.

Based on previous evidence, we know that aggression is a contextual event, and organizational factors may be related to the incidence of the events [5]. These external factors are something that care practices can influence. In our data, systematic reporting, going through the incidents in ward meetings, and informing management were such practices. Our positive finding was that staff is reporting the incidents, which is not always self-evident or daily practice at the hospital level [28]. Fear of consequences and ineffective systems are central examples that may cause underreporting of incidents [29]. Sometimes, incidents can be discussed among staff members, but those are not recorded [24]. It is surely possible that this is also the case in this study, and

some incidents are not reported to the system. In addition, discussing incidents with patients was not described in our data. It is certainly possible that these types of discussions were conducted but not recorded in the system. We find it encouraging that joint staff and patient reviews are conducted after aggression incidents [30]. In order to promote this, structured models for reflection that consider patients' vulnerability and privacy should be developed and implemented. The importance of patient participation and its encouragement in patient safety are well established [31]. Vandewalle et al. [32] investigated how power and responsibility are shared with the patients in psychiatric care concerning patient safety. They reported that, especially on closed wards, nurses have difficulties utilizing patient participation. To support nurses in this, continuing education and support from the management level are needed [32]. Again, education and building a shared understanding could be a key issue for this.

4.1. Reliability. This study has strengths and limitations that should be taken into account when interpreting the results. The data are based on reports from nursing staff. It is known that safety reports often go unreported or only partly completed, causing unreliable descriptions [33]. Although the staff was advised to report all incidents and we likewise included all the reports from the study period, it is possible that this does not cover all the incidents that occurred. In addition, since the reports were in written format, the data are not as profound as they would have been if these included interviews, for instance. The basis for the six-month sample was based on the number of seclusions and safety incidents in the included wards. The numbers were assessed beforehand, and it was concluded that with this time the sample would be representative enough. In addition, during the analysis, it was ensured that the data were saturated and the same categories came out repeatedly. However, it is possible that the data would have been more extensive if including, for example, incidents in one year time. In the safety incident reports, the number of extra patients is mentioned often. Although we have the number of patient beds, we do not have the information regarding the number of patients who exceeded the number of beds. Considering the small number of incidents and the fact that the data are only from one hospital and solely from the nursing staff perspective, generalizations of the results should be made judiciously.

4.2. Implications for Nursing Practice. Although safety incidents did not occur daily, those are invariably present in psychiatric inpatient care, causing fear and discomfort for patients and staff. Considering the harmful consequences, these types of incidents are caused; preventative actions are urgently needed. In future research, there is a need for the development of evidence-based preventative interventions by including the perspectives from patients, nursing staff, medical doctors, and managers. Future research about safety incidents should also be assessed including the perspectives of all of these parties. Lastly, it seems that nursing staff are reporting safety incidents, which is a positive finding that will also help the further development of safety practices from the research point of view.

The safety incidents could partly be prevented by using multidisciplinary and multilevel cooperation and by balancing resources and needs. This also includes multidisciplinary and ward-specific education for safety practices as well as ensuring the balance between resources and patients on the ward. Comprehensively planned care, including workable multiprofessional cooperation and mutual understanding, including patient participation, should also be central in safety issues. In addition, wards should be designed or renovated so that safe environments can be guaranteed.

Data Availability

Empirical data were used to support the findings of this study and are not made available.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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