Exploring the Charge Nurse Role in the Inpatient Psychiatric Unit

By

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Abstract

The United States is experiencing a shortage of psychiatric mental health nurses as the number and complexity of individuals diagnosed and treated for mental health services increases. Psychiatric mental health nurses are equipped with the clinical and leadership skills to address this and are one of the largest providers in the inpatient psychiatric setting characterized by unpredictability, chaos, and violence. As frontline leaders, charge nurses play an essential role in overseeing safety and quality of care in complicated health care environments such as psychiatric mental health. Yet, their role in this specialty has been understudied both nationally and internationally. This study presents a thematic analysis of a series of semi-structured interviews with seven charge nurses in inpatient psychiatric units. Its results illustrate some of the characteristics that nurses in this role face. Further research is warranted on the leadership of charge nurses in these settings to fully understand their current roles and responsibilities and their influence on maintaining patient, staff, and unit safety.

Keywords: acute psychiatric care, charge nurse, inpatient psychiatry, mental health nursing, psychiatric nursing

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Exploring the Charge Nurse Role in the Inpatient Psychiatric Unit

Psychiatric mental health nurses are among the largest groups of mental and behavioral health care providers in the United States (American Psychiatric Nurses Association [APNA], 2019). Even though their work is increasingly vital – especially considering the increasing number of individuals diagnosed and treated for mental health every year –there is a projected shortage of providers (APNA, 2019; Phoenix, 2019). This problem may be further compounded by the lack of interest and understanding of what psychiatric mental health nurses do (Sabella & Fay-Hillier, 2014; Stevens et al., 2013) by future nursing candidates, who are expected to fill these vacancies (APNA, 2019). To recruit and retain nurses in this nursing specialty, the different psychiatric roles should be fully understood (Cleary et al., 2011; Hercelinskyj et al., 2014; Redknap et al., 2015), from the frontline workers and leaders to upper nursing management and executives. To this end, this thesis focuses on the frontline leadership role of the charge nurse, defined as a registered nurse (RN) of an acute-care unit responsible for the management and supervision of the unit activities and care provided (Eggenberger, 2012). Its goal is to build an understanding of what it is like to work in this difficult role.

Psychiatric mental health nurses have been studied extensively in the inpatient acute care environments (Delaney & Johnson, 2006; Shattell et al., 2008); this environment serves as the primary setting of this thesis. Nurses in this setting provide 24-hour care for individuals undergoing acute crises, who can also exhibit individual behaviors, characteristics, and diagnoses that contribute to the unit's violent and unpredictable nature (Iozzino et al., 2015). Psychiatric mental health nursing (PMHN) focuses on the interpersonal relationships developed between health care providers and patients (Fourie et al., 2005). Widely known as “therapeutic relationships,” it allows the nurse to gain a deeper “understanding of the patients and their

experiences" as multifaceted beings with "unique backgrounds and in need of individualized care" (Salberg et al., 2019, p. 1830). Nurses use this information to engage and educate patients on managing their symptoms and coordinating and facilitating their care with other providers (Fourie et al., 2005). These nurse-patient relationships are valued by psychiatric nurses and are reportedly beneficial in reducing the risk of violent behaviors, thus maintaining unit safety (Delaney & Johnson, 2006; Hamrin et al., 2009).

As the main pillar of psychiatric nursing, developing therapeutic relationships takes time (Shattell et al., 2008) and depends upon maintaining safety, which requires staff to be diligent and attentive (Delaney & Johnson, 2006) to the ever-changing needs of the patients and the unit. However, psychiatric nurses report a large conflict with the organizational constraints and roles they are expected to fill (Berg & Hallberg, 2000; Fourie et al., 2005; Hummelvoll & Severinsson, 2001; Shattell et al., 2008), that contribute to their feelings of emotional burden (Kindy et al., 2005) and moral distress (Deady & McCarthy, 2010). This bleak picture is further compounded by psychiatric nurses feeling unsupported by nursing management (Shattell et al., 2008). Individuals in these positions are seldom present on the unit or directly involved in patient care (Berg & Hallberg, 2000; Gabrielsson et al., 2016). These ongoing challenges continue to have negative implications for the psychiatric nursing workforce, contributing to poor work performance and threatening staff's ability to maintain the safety of the unit (Kelly et al., 2015). Thus, it is no surprise that studies continue to identify the importance of strong management and leadership in the acute psychiatric setting (Hanrahan et al., 2010a). Frontline leadership roles at the patient-unit level, such as the charge nurse, make up for this gap between administration and direct care providers (Sherman et al., 2011; Weaver et al., 2018). Considered a core member of the patient care team (Weaver et al., 2018), the charge nurse plays an essential and necessary role

in the supervision and accountability for staff, patient, and unit activities (Connelly et al., 2003b). They are actively involved in the unit and patient care 24-hours a day, and they represent administration during evening/night hours and weekends (Connelly et al., 2003b). As part of the general nursing organizational structure, charge nurses are relied on by nurse management "to assume responsibility for quality outcomes and help meet the growing number of organizational performance measures" (Sherman et al., 2011, p.2).

As defined above, the charge nurse is an RN who supervises and manages the unit activities (Eggenberger, 2012). While this suggests any staff RN can be assigned this role, there are differences between staff nurses who assume charge nurse positions and non-charge nurse positions (Wilson et al., 2012). Studies have found differences between their perceptions of teamwork, overall unit safety (Wilson et al., 2012), and their actual time spent on their role components (Seed et al., 2010). For instance, Wilson et al. (2012) found charge nurses viewed the patient safety culture less positively than non-charge nurses, speculating they are more aware of the potential and actual safety hazards than non-charge nurses. This suggests the broader scope of practice charge nurses have in this setting that influences the delivery of routine and crisis care (such as leading the health care team) compared to non-charge nurses.

Some studies suggest charge nurses in specialty areas such as PMHN have specific skills and competencies necessary for effective performance (Cleary et al., 2011; Fourie et al., 2005; Hanrahan et al., 2010a; Regan-Kubinski, 2009). For instance, Fourie et al. (2005) found non-psychiatric nurses "could rarely function in their full capacity because of their unfamiliarity with the ward and the patients… permanent staff nurses would have to carry extra workload" (p. 137). Additionally, psychiatric units see longer lengths of stays and higher risks of patient-to-nurse violence compared to other departments (Yada et al., 2020). These suggest specific competencies

and work environments may differ from that of non-psychiatric nurses (Yada et al., 2020). This also suggests that the medical units' charge nurse skills and competencies may not translate easily to psychiatric units.

Charge nurses in this setting work within a team composed of various licensed (e.g., registered nurses, licensed vocational nurses, certified nursing aides) and unlicensed staff (e.g., unlicensed assistive personnel, mental health technicians), each of which is assigned their tasks or patients (Sherman & Eggenberger, 2009). As the designated team leader (Cahill et al., 1991; Kalisch et al., 2009), charge nurses must be knowledgeable about staffing numbers and staff's various qualifications to make appropriate nurse-patient assignments pertinent to maintaining unit safety and managing violent behaviors (Cahill et al., 1991; Kalisch et al., 2009; Tomey, 2009). They must also facilitate communication between staff to promote teamwork (Kalisch et al., 2009). They ensure overall safety by effectively organizing, managing, and coordinating activities and personnel during the crisis, as they have a broader understanding of the unit's ebb and flow (Cahill et al., 1991). Thus, charge nurses with their team of staff are imperative to providing quality of care and patient safety (Firth-Cozens, 2001).

Study Purpose

Eggenberger (2012) suggests that expectations of charge nurses may differ amongst the various areas of nursing. Across national and international studies, none have focused on this role in inpatient psychiatric units. Patient safety presents its unique challenges (Kindy et al., 2005; Thibaut et al., 2019), such as specialized interventions, trainings, and treatments for the patient population. Thus, extant research on charge nurses cannot be generalized based on specific needs and challenges working in psychiatric units.

This study begins to address some of these issues and lacunae. By investigating what it is like to work as a charge nurse in psychiatric mental health, this study hopes to bring into light some of the unique characteristics that charge nurses face. In doing so, this study aims to provide insight from their accounts into their role as frontline leaders on inpatient psychiatric units. This can offer a better understanding of their work to increase their acceptance and appeal, while perhaps contribute to the declining recruitment and retention in psychiatric mental health (Cleary et al., 2011; Hercelinskyj et al., 2014; Redknap et al., 2015). While this study cannot hope to provide all the data and analysis that will improve PMHN policy and training, it nevertheless represents a vital departure from past trends.

Significance

The specialty of PMHN needs to fill at least 250,000 positions by the year 2025, which comes on top of a 58% increase in vacant psychiatric RN positions (APNA, 2019). In addition, American Association of Colleges of Nursing [AACN] (2020) projects a 0.3 million (7%) demand for nurses from 2019 to 2029. The need for more nurses in this field comes with the increasing number of U.S. adults experiencing mental illness over the years. In 2018, an estimated 47.6 million U.S. adults experienced "any mental illness", defined as a "mental, behavioral, or emotional disorder… ranging from no impairment to mild, moderate, and even severe" (National Alliance on Mental Illness [NAMI], 2019; National Institute of Mental Health [NIMH], 2019, para. 3). About 43% of them received inpatient treatment (NAMI, 2019, para. 7). In addition, 11.4 million U.S. adults experienced "serious mental illness", defined as "mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities," (NAMI, 2019; NIMH, 2019, para. 4). About 64% of them received inpatient treatment (NAMI, 2019, para. 8).

In light of the COVID-19 pandemic, these numbers are projected to increase as more individuals of all ages experience heightened levels of anxiety, depression, suicidal ideation, and substance use (Reinert et al., 2020). For example, between 2019 and 2020, the prevalence of anxiety disorders increased by 25.5% compared to 8.1% in 2019 (Czeisler et al., 2020). The pandemic has also shown an increase in psychiatric diagnosis for individuals who had no previous psychiatry history but were diagnosed with COVID-19 (Taquet et al., 2021). Consequently, these occurrences correlate to an increase in demand for mental health services (WHO, 2020), as the mental health effects from this pandemic alone are projected to linger following its resolution (Bojdani et al., 2020).

The psychiatric mental health workforce is equipped with the clinical and leadership skills to address the population's growing mental health needs (APNA, 2019). As the inpatient psychiatric unit's frontline leaders, charge nurses are expected to fully utilize their education and training and collaborate with other providers of the team to deliver quality care and address mental health outcomes (Institute of Medicine [IOM], 2010; Kameg, 2020). With the important contribution charge nurses play and the under research of their role (Seed et al., 2010), it is worthwhile to direct more research towards understanding this unique position.

Search Strategy

To better focus the design of the semi-structured interviews, a literature review was conducted to identify relevant prior research on psychiatric charge nurses. Specifically, a literature search was conducted in January 2020 utilizing PubMed, CINAHL, Scopus, and Google Scholar. The following keywords were used in the psychiatric nursing literature: *charge nurse, psych* OR mental health, acute OR inpatient care*. The initial search yielded 1,205 articles. The search was then limited to U.S. publications and academic journals, yielding 439

articles. The titles and abstracts were reviewed, and eight articles were included based on the following: acute care/inpatient setting and studies that discussed the nursing role in the psychiatric unit. Articles were excluded if they were set in non-acute care/inpatient settings (e.g., outpatient clinics, psychiatric jails), did not focus on the nursing role in this setting, or focused on the patient.

The underrepresentation of charge nurses in their samples required a separate review of the role. The following keywords were used in the charge nurse literature: *charge nurse, competencies, preparation,* and *development*. The initial search yielded 1,260 articles, then limited to U.S. publications and academic journals, resulting in 403 articles. Articles were excluded if they did not specifically focus on the charge nurse role (e.g., assistant nurse manager) and their skills, competencies, and qualities. Seven articles were chosen based on their focus on the skills, competencies, and qualities of a charge nurse in general acute care settings. In total, 15 articles between charge nurses and psychiatric nursing were chosen for the literature review.

Literature Review

As noted above, the purpose of this review is to use a synthesis of the literature about the role of the charge nurse and working in a psychiatric environment to inform the design of this study's semi-structured interviews. However, most of the studies on the charge nurse role were conducted in acute medical settings, while many of the studies on the psychiatric work environment were from the non-charge nurses' perspectives. This observation is consistent with a number of the broader trends we noted previously. Still, it does mean that the literature search can only provide background themes and topics, as opposed to specific research questions that extend or complete existing lines of research.

The Charge Nurse Literature

Accordingly, the following background themes and topics were identified. Research into the charge nurse role frequently takes the form of qualitative studies (Eggenberger, 2012; Patrician et al., 2012; Sherman et al., 2011; Wilson et al., 2011), often uses grounded theory (Cathro, 2016), and often employs nonexperimental designs (Wojciechowski et al., 2011). The main sampling techniques include convenience, purposeful, and snowballing (or participant referrals) of charge nurses and nurse administrators. Chosen sampling techniques ensured that the sources were reliable and had knowledge of the research topic (Polit & Beck, 2014). Furthermore, incorporating different levels of nurse leadership provides insight into the differences and similarities of expectations from those in the role. Primary sources of data collection include interviews and surveys developed by the researchers. All interviews used semi-structured questioning, two of which used interview guides, with one based on Katz' management skills framework (Connelly et al., 2003b). Three out of the five interviews were audiotaped (Cathro, 2016; Patrician et al., 2012; Wilson et al., 2011). Coding, content, or comparative analysis were used by the primary researcher and verified by either a secondary researcher and/or content expert.

Unlike the putatively replicable nature of quantitative designs, qualitative research norms usually are understood to require researchers to address the rigor or trustworthiness of their findings in a self-contained framework. This convention was addressed in various ways across the studies, ranging from audit trails to member checking. Most of the studies utilized member checks to enhance the credibility and dependability of their findings (Cathro, 2016; Connelly et al., 2003b; Eggenberger, 2012; Sherman et al., 2011; Wilson et al., 2011; Wojciechowski et al., 2011).

The charge nurse role has evolved due to the diverse and medically complex patient population needing safe, high-quality care (Patrician et al., 2012). Research into the modern-day charge nurse identifies current competencies, qualities, learning/developmental needs, and skills required to be influential frontline leaders (Cathro, 2016; Connelly et al., 2003b); Patrician et al., 2012; Sherman et al., 2011; Wilson et al., 2011; Wojciechowski et al., 2011). Some of these studies also addressed the challenges and barriers of the role (Patrician et al., 2012). Developing the knowledge on how charge nurses are effective in their role is important to understand how they contribute to patient safety and high-quality of care.

Competencies

The competencies and skills of charge nurses were studied in acute medical settings via surveys and interviews using qualitative approaches (Connelly et al., 2003b; Eggenberger, 2012; Sherman et al., 2011). The charge nurse position encompasses a range of technical, critical thinking, organizational, and human relations skills (Connelly et al., 2003b) to manage the responsibilities of being a clinician and a leader.

Communication. All studies identified communication as an essential skill that can make a difference in patient care (Cathro, 2016; Connelly et al., 2003b; Eggenberger, 2012; Sherman et al., 2011; Wilson et al., 2011; Wojciechowski et al., 2011). This skill is used in all aspects of their job, such as one-on-one interactions with their patients, providing hand-off reports between shifts, and informing clinicians about a patient's change in status (Cathro, 2016; Eggenberger, 2012; Wilson et al., 2011). Although communication is a critical skill, few studies explore charge nurses' use of effective communication (Patrician et al., 2012; Wilson et al., 2011). Most participants described communication as verbal (Wilson et al., 2011) or tools (such as patient notes) (Sherman et al., 2011) and neglected the possible influence of nonverbal interactions that

can enhance understanding (Denham & Onwuegbuzie, 2013). Charge nurses should also consider the cultural and generational influences on communication (Patrician et al., 2012; Sherman et al., 2011). For example, understanding the meaning one attaches to a word or phrase can hinder or promote communication effectiveness between a charge nurse and a new graduate nurse (Patrician et al., 2012). Thus, it is difficult to say exactly how charge nurses know that their communication was effective. Charge nurses could benefit from learning this as communication is a pillar to other charge nurse competencies such as relationship building, conflict management/resolution, and staff education (Eggenberger, 2012).

Leadership. Further findings suggest charge nurses view themselves as team leaders and therefore, a role model or example for the staff (Connelly et al., 2003b; Patrician et al., 2012; Sherman et al., 2011). They understand they are responsible for providing guidance and support to not only the nursing staff but other clinicians with whom they worked (Eggenberger, 2012; Wilson et al., 2011). This means they need a wealth of administrative knowledge of the policies and procedures in addition to their clinical judgment (Wojciechowski et al., 2011). This knowledge is utilized to educate staff and patients and make critical decisions on the spot, such as when to call a medical code for emergent interventions (Eggenberger, 2012). Notwithstanding, none of the studies address how charge nurses develop these leadership skills and knowledge. This would benefit nurses who are interested in the charge nurse role or new graduate nurses who lack clinical expertise.

Although leadership qualities and characteristics were studied (Connelly et al., 2003b; Sherman et al., 2011), additional research is needed to identify the leadership style most effective in managing a team (Cathro, 2016). Further studies are needed in various hospital settings to address any additions or differences in the competencies and skills identified thus far. These can

influence the components of programs, orientations, and educational tools for continued charge nurse development (Connelly et al., 2003b; Eggenberger, 2012; Patrician et al., 2012).

Barriers and Challenges

Qualitative studies were also conducted to investigate the barriers and challenges charge nurses of acute medical settings encountered (Patrician et al., 2012; Sherman et al., 2011; Wojciechowski et al., 2011). Charge nurses identified conflict management amongst staff and between health care professionals as one of the most difficult to address (Sherman et al., 2011; Wojciechowski et al., 2011). Their lack of training on conflict resolution (Sherman et al., 2011) made them feel unprepared to handle arduous situations, personalities, and attitudes (Cathro, 2016; Eggenberger, 2012; Patrician et al., 2012). If left unresolved, the conflict between members of the patient's team can create inconsistency of care and near-miss errors (Eggenberger, 2012) that can present a threat to patient safety and quality of care. Conflict resolution courses were identified as a top learning need by charge nurses to address this barrier (Eggenberger, 2012; Patrician et al., 2012; Sherman et al., 2011) and are also recommended by researchers to be effective leaders (Cathro, 2016; Connelly et al., 2003b; Eggenberger, 2012; Patrician et al., 2012; Sherman et al., 2011; Wilson et al., 2011; Wojciechowski et al., 2011). Further research is needed on what to include in this curriculum and evaluate-its effectiveness on participants in the short and long-term.

Charge nurses also reported difficulty in balancing their administrative and clinical roles (Patrician et al., 2012). As the resource person for the unit (Connelly et al., 2003b; Wilson et al., 2011), they sometimes struggled with meeting expectations from their superiors, the organization, their staff, and their patients (Cathro, 2016; Eggenberger, 2012; Patrician et al., 2012). They also felt like they lacked the resources or support to do their job, whether it was

medical equipment or managerial feedback (Patrician et al., 2012). Some charge nurses were also required to take on a patient load in addition to their responsibilities, making it more difficult to extend their help for other nurses and patients (Patrician et al., 2012). Finding a balance between direct patient care and administrative work seems to be a generalized struggle of charge nurses. Research on how charge nurses cope with this ambiguity can provide insight into the balancing practice and gaps to target. Additional research on the nursing administration perspectives regarding this obstacle may elicit discussion on clearer charge nurse role delineation.

The Psychiatric Mental Health Nursing Literature

The literature review of psychiatric mental health nursing in the United States was a mix of cross-sectional quantitative (Hanrahan & Aiken, 2008; Hanrahan et al., 2010a, 2010b), phenomenology (Kindy et al., 2005; Shattell et al., 2008), grounded theory (Delaney & Johnson, 2006), and time-motion, correlational (Seed et al., 2010) designs. The primary sampling techniques include purposive (Delaney & Johnson, 2006; Kindy et al., 2005), convenience (Seed et al., 2010; Shattell et al., 2008), and snowballing (Kindy et al., 2005) of psychiatric nurses in the United States. Main sources of data collection include secondary analysis (Hanrahan et al., 2010a, 2010b), interviews (Kindy et al., 2005; Shattell et al., 2008), surveys (Delaney & Johnson, 2006; Hanrahan & Aiken, 2008; Privitera et al., 2005; Seed et al., 2010), nonparticipant observations (Delaney & Johnson, 2006), and audio-taped (Delaney & Johnson, 2006; Kindy et al., 2005; Shattell et al., 2008).

The psychiatric literature focused on the role of the psychiatric nurse and the psychiatric work environment. These factors present challenges for nurses that work in acute psychiatric settings. Some challenges include conflicts with the psychiatric nursing role and the need for

additional support from administration and clinicians. These challenges can have negative implications on the workforce and, inevitably, the patient population they serve.

Psychiatric Nurse Role Conflict

Some studies identified conflicting views for the psychiatric mental health nurses between their personal beliefs about what is best for the patient versus their colleagues (Cahill et al., 1991) and management (Seed et al., 2010). This has resulted in feelings of moral distress, usually transpired from a disconnect between the helpful aspect of the profession and the reality of their work (Kindy et al., 2005; Shattell et al., 2008). This conflict was seen over the use of restrictive interventions such as seclusion or restraints (Cahill et al., 1991), as some nurses resorted to these for the sake of convenience or punishment (Olofsson & Norberg, 2001). This can create a divide with other nurses whose care beliefs include establishing rapport with patients and utilizing the least restrictive measures to maintain therapeutic relationships (Delaney & Johnson, 2006; Seed et al., 2010).

Further contributing to psychiatric mental health nurses' moral distress is the struggle in balancing their roles and responsibilities. For instance, nurses felt bound by the required administrative and secretarial tasks, such as documentation and paperwork (Seed et al., 2010) and dealing with staff shortages (Shattell et al., 2008). It was not the task itself that was burdensome, but the time spent on these required tasks, such that the more time spent on paperwork, the less time spent on direct patient care (Seed et al., 2010). Nurses felt pressure from the administration to manage responsibilities while simultaneously providing direct patient care within their shift to avoid overtime (Shattell et al., 2008). This picture is further complicated when the unit is inadequately staffed (Hanrahan & Aiken, 2008; Shattell et al., 2008), another common challenge reported by psychiatric mental health nurses. The time-constraint and lack of

resources elicited feeling torn between providing high-quality care and completing the expected administrative workload (Hanrahan & Aiken, 2008; Shattell et al., 2008). Sufficient evidence exists regarding the impact of moral distress on psychiatric nurses, such as burnout (Ohnishi et al., 2010) and job dissatisfaction (Ando & Kawano, 2018), that can eventually lead to staff reactivity towards patients (Shattell et al., 2008) or leaving the department (Hanrahan & Aiken, 2008).

Inevitably, less direct patient care impacts interventions and treatments crucial to the chronic nature of their diagnoses, such as having less time teaching their patients how to manage their symptoms (Seed et al., 2010; Shattell et al., 2008). Some patients developed resentment as they felt the rush in nursing care, further hindering the therapeutic relationship (Shattell et al., 2008). Some patients also reported that neither the hospitalization nor the professionals helped them or understand how to treat them (Shattell et al., 2008). Further studies are needed to investigate the influence of the psychiatric nurse's feeling of inability to provide patients the foundational care on their lack of fulfillment in their role. By understanding this impact, charge nurses can help mitigate through delegation, patient-nurse assignments, or collaboration with upper management to provide staff nurses more time for direct patient care (Cathro, 2016).

The Psychiatric Work Environment

The psychiatric work environment presents its challenges related to the organizational practices and patient and unit characteristics. Some studies reported challenges between administration and clinicians and psychiatric mental health nurses, contributing to their struggles in performance (Hanrahan & Aiken, 2008; Hanrahan et al., 2010a; Kindy et al., 2005; Shattell et al., 2008). Nurses often reported feeling blamed, punished (Kindy et al., 2005), criticized, unsupported, "shutting down" (Shattell et al., 2008), and lack of acknowledgment (Hanrahan &

Aiken, 2008) from their superiors. Behaviors and decisions of clinicians, such as social workers and physicians, also affected nurses' performance and providing safety, such as lowering medication dosages for high-risk patients, inconsistency in care, and not being available to talk with patients about their treatment (Kindy et al., 2005). These negative interactions with clinicians contributed to nurses' "poor morale" (Kindy et al., 2005, p. 172), which can result in interactions that are not beneficial to the patients and their colleagues (Shattell et al., 2008). Charge nurses are able to act as a liaison between staff nurses and management (Hanrahan et al., 2010a) and help facilitate collaboration between staff nurses and clinicians needed for consistent and safe patient care (Cathro, 2016).

The perceived lack of support and resources complicates the number of patient care challenges nurses must prepare for, such as violence and aggression (Cahill et al., 1991; Kindy et al., 2005; Privitera et al., 2005). The risk of these events occurring increases based on the patient's specific psychiatric diagnoses and conditions, such as "impulsiveness, explosiveness, and feeling superior to and antagonistic toward staff" (Kindy et al., 2005, p. 172). Sometimes, the "locked" hospital environment itself can contribute to patient's aggressive behaviors (Shattell et al., 2008). For instance, some patients felt "imprisoned and confined," contributing to their feelings of agitation, which can manifest into threats and assaults (Shattell et al., 2008, p. 245). At this point, clinical and non-clinical staff must act swiftly and in unison to regain the unit's safety. This can be done by a variety of prevention and intervention strategies, such as building therapeutic relationships with patients (Delaney & Johnson, 2006), verbal de-escalation (Delaney & Johnson, 2006), seclusion, and restraints (Cahill et al., 1991). In these situations, crisis leaders such as the charge nurse are important to orchestrate and maintain the safety of all involved (Cahill et al., 1991). Charge nurses must be skilled, confident, and knowledgeable, as any fear or

uncertainty picked up by the patient can contribute to the patient's own uncertainties and will not reduce their fear (Cahill et al., 1991).

Psychiatric mental health nurses have dealt with these obstacles as they are at the frontline of patient care, putting them at the highest risk of threats and assaults than clinicians and non-clinicians (Hanrahan & Aiken, 2008; Kindy et al., 2005; Privitera et al., 2005). Their long-term exposure to these challenges and feelings of dissatisfaction can contribute to their burnout and intent to leave, affecting quality care and patient safety (Hanrahan & Aiken, 2008; Hanrahan et al., 2010a). Research suggests organizational factors such as manager skill and leadership, nurse-physician relationships, and better staffing ratios can contribute to positive work environments that lower psychiatric nurse's burnout (Hanrahan et al., 2010b). As frontline leaders, charge nurses possess the decision-making skills, resourcefulness, and awareness of the big picture, that affect the unit atmosphere and patient care (Wilson et al., 2011). Thus, further examination on the charge nurse's leadership in this specialty setting can provide insight into how they could help address these challenges and their influence on recruitment and retention, job satisfaction, and better patient outcomes (Hanrahan et al., 2010a).

Primary Research Introduction

Most of the literature on charge nurses and inpatient psychiatric units gives a descriptive account of their role and the unit activities, providing a visualization of what it is like to be in the role and environment. What is usually not visible in descriptive accounts is the individual's personal experience and interpretation of being a charge nurse or working in an inpatient psychiatric unit. Thus, as discussed above, the purpose of this study is to explore the experiences of being a charge nurse on an inpatient psychiatric care from the perspective of charge nurses themselves, thereby centering the uniqueness of their experience and their role in providing

healthcare. More specifically, the goal of this study is to identify a small number of essential themes that represent common, central categories of thought and experience with the idea that these themes could provide a starting point for further research about psychiatric charge nurses.

Research Design

A qualitative, descriptive approach was utilized to obtain an understanding of the experience of being a charge nurse in an inpatient psychiatric unit through their individual accounts (Creswell & Poth, 2018). Participants shared their experiences related to being a charge nurse, thereby providing insight into the meaning and significance by way of their interpretations of their experience and the choices about what language to use. Their accounts can also provoke underlying feelings, emotions, and reflections that can be interpreted on a level that is not easily accessible, even to the participant (Crist & Tanner, 2003). Accordingly, this study aimed to not merely describe how to be a charge nurse on an inpatient psychiatric unit, but to bring forth a deeper level of what it means to be and how one manages an inpatient psychiatric unit as a charge nurse.

Setting

Interviews were conducted via telephone or web-based conferencing (e.g., WebEx) mainly due to the COVID-19 pandemic at the time of the study. In-person interviews with social distancing practices were also offered as an option. Participants chose the date and time of the interview but were encouraged to consider a quiet space in their preferred location and to have an optimal state of mind in hopes to provide richer information.

Sample

Sample sizes in qualitative research vary based on the study's purpose, research question, and richness of data (Elo et al., 2014). However, the quality of the data obtained from interviews ultimately drove the sample size of the study. Quality was based on the primary researcher developing a "clear understanding, description, and potential interpretation of the phenomenon of interest" (Patton, 2019, p. 284), and "no new information or themes were observed in the data" (Guest et al., 2006, p.59).

The targeted study sample includes registered nurses (RNs) who currently held the charge nurse (CN) position in inpatient psychiatric units in acute care hospital settings. The hospitals were a mix of public and federal sectors. All hospitals treated patients that had a variety of mental health and substance use diagnoses. There was no discrimination in the unit's type of patient population (e.g., adolescent, adult). Eligible participants included: actively licensed as an RN; currently take on the role of charge nurse at least 25% of the time during the week, and currently working in an acute inpatient psychiatric unit. Those excluded include nurses who did not hold a registered nurse license, nurses working at other psychiatric facilities such as outpatient psychiatric units, medical-psychiatric units, forensic psychiatric units, and rehabilitation facilities, and nurses of administrative positions (e.g., nurse managers, assistant nurse managers, nursing supervisors) as they do not provide direct patient care. It is of note that the title of the assistant nurse manager is synonymous with the title of charge nurse (Sherman et al., 2011). However, the facilities either did not have an assistant nurse manager position or identified an assistant nurse manager as a separate position from the charge nurse that holds more of an administrative role than a clinical role.

A purposive sample of seven RNs were recruited from two local inpatient psychiatric hospitals in Northern California. This sampling method was utilized based on the phenomena; thus, all participants must have current experience as a charge nurse working in an inpatient psychiatric facility to provide an 'accurate' account of the phenomena under study (Polit & Beck, 2014). Flyers were handed out, emailed, or texted to informants by the researcher. They were also encouraged to refer charge nurses of local inpatient psychiatric units to gather as much data to inform the study (Polit & Beck, 2014). Participants were pre-screened via telephone to determine eligibility. Once eligibility was determined, a separate interview was scheduled. See Appendix A for a sample of the recruitment flyer and Appendix B for the telephone screening script.

Ethical Considerations

The study was approved by the academic University's Institutional Review Board. During the telephone pre-screening, participants were provided information on their rights as a subject, the purpose of the interview, how the data will be used, their right to remove themselves at any time from the study, and how their personal information will be protected (confidentiality). Issues brought up by the participant or the interviewer that provoked sensitive responses were left to the discretion of the participant to elaborate or not. They were notified about the use of a tape recorder during the interview and its purpose. An opportunity for questions and answers were provided, along with the contact number of the researcher for further questions. They were provided a copy of the consent form. On the day of their interview, participants were informed once audio-recording began, and their voluntary participation and ability to decline further participation at any time during the study. Verbal consent was obtained prior to proceeding with the interview. Each participant was documented as Participant 1,

Participant 2, etc., to maintain confidentiality. None of the participants declined to be audio-recorded.

Data Collection

Data collection occurred via the participant's choice of telephone or WebEx conferencing. No subjects opted for the in-person interview. Demographics were first collected by the researcher asking the question, providing the participant the answer options, and circling the participant's answer. Demographic data obtained included age, number of years as a registered nurse, number of years working at current hospital, number of years as a charge nurse, how many ancillary staff they oversaw, how often they were charge nurse, what unit population they are charge of, and how long they have been a charge nurse of that unit.

Semi-structured interviews were conducted to allow in-depth discussion of participants' experiences. The interview opened with either, "Tell me your experiences of being a charge nurse in an inpatient psychiatric unit" or "Please share with me and talk to me about what it is like for you to be a charge nurse of an inpatient psychiatric unit" to elicit the participants' personal experience to the research topic (DeCarlo, 2018). Participants were provided uninterrupted time to share their experiences. Careful attention to the participants' situations, concepts, words, or phrases used gave rise to subsequent questions such as "tell me more about…" for elaboration or "tell me about a time when…" for clarification. Those shared from previous interviews were also used as follow-up questions to gain their personal understanding (Patton, 2019).

Interview duration ranged from 60 minutes to 90 minutes. At the end of the interview, participants were offered an opportunity to give additional information that they felt was

pertinent to the main question. All participants received a $25 gift card as an appreciation for their time. The researcher's contact number was provided if they had further questions.

Data Analysis

Methodological Framework

The qualitative technique of directed thematic coding was used to identify critical themes or deep patterns in the verbal explanations that study participants provided in response to questions asked about topics connected to their experiences (Assarroudi et al., 2018; Vaismoradi et al., 2013). It, therefore, can be used to answer similar research questions as more general phenomenologically-oriented research methods. Still, this approach depends upon simpler and less metaphysical assumptions about reality, the nature of the mind, and the interplay of thought and language. Although there are different approaches to applying this method, directed thematic coding rests primarily on the coder's ability to understand the meaning of what a participant reports by understanding the implications of the words that a speaker uses (Grice, 1968). Because the researcher in this project has experience working as a charge nurse in an inpatient psychiatric unit, and therefore very well positioned to understand the implications of the verbal data provided by participant's spoken data (the interview "speaks the language" of the participants), the method of directed (i.e., guided by expert knowledge of the subject domain) thematic coding is well-suited to the research question.

It also must be acknowledged that being in this position of expertise can risk imposing the researcher's biases onto the data. Eighteen months prior to data collection, the researcher worked for seven years as an RN and charge nurse (for at least 50-100% of the time) in the inpatient psychiatric setting at both private and federal health care facilities. Thus, controlling for the tendency to see in the data what one already believes, conscious attempts were made to

address and minimize biases through triangulation methods during data collection and analysis and are further described under the data trustworthiness section.

That said, it is important to understand that there is no such thing as bias-free research – and that expertise can be a lever by which important insights can be generated. This is an important idea to keep in mind, because, as many qualitative researchers have stressed, "complete objectivity might never be fully obtained" (Hegelund, 2005, p. 654), and so researchers need a strategy that allows their pre-existing beliefs to contribute, not detract from, the reliability of the project. This is such a project, as the categories of scientific interest are third-person descriptive categories, and the participants speaking in a language accessible to the researcher.

In light of these and other considerations, the directed coding method was chosen as it relies on the researcher's expertise lens to confer insight and understanding of the meaning and language of what participants use. But this method also prevents a researcher from rendering their particular opinions or values into the data, as it permits inductive generalization only when there is strong evidence of associative connection in the inductive basis. The inductive base itself is strengthened by the researcher's lens, as its quality is partly a matter of the researcher knowing the conventions of the language used by participants to assist in constructing the foundational interview data.

In preparation for analysis, the researcher transcribed each recording verbatim immediately following the interview (Poland, 1995, as cited in Assarroudi et al., 2018, p.49). Each recording was relistened to against the completed transcription to verify its accuracy. The researcher familiarized themselves with the data by rereading transcripts and relistening to the recordings. This provides a general sense of the participant's "world" and patterns of sense-

making, with the goal to grasp the full implications of the words that the participant used (Assarroudi et al., 2018). Each transcript was read line-by-line, notating nonverbal cues (e.g., intonation, pauses, hand gestures) and meaning units such as repeated words/phrases, concepts, and statements that described their experience in being a charge nurse of the unit. These meaning units were interpreted and summarized by the researcher giving rise to seven categories; each assigned a color and "coding rules" to provide a clearer distinction between categories (Mayring, 2014, as cited in Assarroudi et al., 2018). These codes were further reduced considering their frequency of occurrences to capture shared ideas and experiences, proximity in the text (Vaismoradi et al., 2013), and "their meanings, similarities, and differences" (Assarroudi et al., 2018). See Appendix D for more details on the induction of the general categories. Finally, the individual level categorizations of the different categories of expression were collected and organized inductively into two final themes, which are reported in detail below. See Appendix E for an example of theme 2's induction process from meaning units to the final theme.

The iterative nature of directed thematic coding allows the researcher to repeatedly immerse in the data to understand the participant's view and develop interpretations within and across the transcripts (Peat et al., 2019). To stay true to the study's purpose, the researcher continually asked these questions throughout the process: "how does this provide insight into being a charge nurse of an inpatient psychiatric unit?" and "what new insight can this provide in being charge nurse of an inpatient psychiatric unit?" An idiographic approach was used that examined one transcript thoroughly before moving on to the next (Smith & Osborn, 2007). After each transcript, the researcher temporarily put aside what was learned from previous transcripts to see the data through a new "lens" or other possibilities of interpretation (Peat et al., 2019).

Data Trustworthiness

Critics of qualitative research often focus on the replicability and reliability of the methods and, thus, its results (Nowell et al., 2017). However, the subjective nature of qualitative research makes pure replication difficult – it is unlikely that two people chosen at random would draw exactly the same qualitative conclusions from any particular set of scientific evidence. Therefore, qualitative researchers strive for trustworthiness, the qualitative equivalence to empirical validity and reliability (Polit & Beck, 2014). Although the attempt to address trustworthiness through these criteria ~~is~~ available, there is no clear delineation or structure for how each of these components should be accomplished (Tobin & Begley, 2004). However, its goal is for the researcher to be transparent in their approach throughout the study and how they arrived at the results (Nowell et al., 2017).

The four criteria to establish trustworthiness are credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility ensures the researcher's understanding aligns with the participant's perspective of the phenomena (Tobin & Begley, 2004). This was accomplished through actions that strengthened researcher credibility, i.e., the primary researcher was the sole data collecting instrument and primarily involved in analysis (Polit & Beck, 2014). The researcher ensured verbatim transcription of the interviews, multiple readings of the text and listening to the audio recordings, field notes, and confirming the participant's experience during the interview by restating or requesting for elaboration of their answers. Person triangulation was also used to compare perspectives of the studied phenomena by collecting data from charge nurses of different hospitals and years of experience (Polit & Beck, 2014, p. 327). This could assist in capturing an overall view of the charge nurse experience in the inpatient psychiatric setting, validating what is shared (and not shared) by the participants.

Transferability involves the possibility for the findings to be applied to similar groups or settings, while not claiming the study's findings are generalizable (Polit & Beck, 2014). This was accomplished by providing examples and exemplars verbatim from the data so other researchers can decide how likely this can be applied to their outcomes. Dependability ensures an outside researcher can understand how another researcher conducted their study in a way that can be followed (Tobin & Begley, 2004). This was accomplished through audit trails in interview notes and transcript documentation that show how the researcher arrived from the initial to the final analysis. Lastly, confirmability ensures that the participant data is what drove the interpretations and the findings (Tobin & Begley, 2004). This was accomplished through reflexive journaling and memo writing to document the process, activities, and discussions about the themes with the co-principal investigator (Lincoln & Guba, 1989, as cited in Nowell et al., 2017). Furthermore, the data were triangulated against other literature findings to provide a consistent and comprehensive picture of the topic under study (Polit & Beck, 2014).

Results and Findings

As noted above, the data was examined by directed thematic coding to develop a deeper understanding of the charge nurse's role in inpatient psychiatric settings (Assarroudi et al., 2018; Vaismoradi et al., 2013). The data generated by this process were subsequently analyzed using a simple direct-code procedure that aimed to identify a small number of "critical themes" in the transcripts. These critical themes represent areas of shared experiences, beliefs, or understanding across all participant interviews, and thus can function as a gateway to further qualitative studies of charge nurses in inpatient psychiatric nurses.

Demographics

Participants were registered nurses (RNs) (*n*=7) who held the charge nurse position in an inpatient psychiatric unit in Northern California. Most of the participants were female (*n*=6). Participants ranged from 21-60 years old—43% were 41-50 years old, 29% were 51-60 years old, 14% were 31-40 years old, and 14% were 21-30 years old. A little more than half of the participants had been a RN for 6-10 years (57%), 29% had been a RN for one to five years, and 14% had been a RN for 20 or more years. Most of the participants were employed full-time (71%), while the remaining 29% worked part-time. All participants worked 8-hour shifts. Forty-three percent of participants had one to five years of experience working in psychiatric settings, 29% had six to ten years, 14% had 11-15 years, and 14% had 16-20 years. Seventy-one percent of the participants had one to five years working as a charge nurse in an inpatient psychiatric setting, while the remaining 29% had six to ten years. Eighty-six percent of the participants held the charge nurse position in their current workplace for one to five years, while 14% held the charge nurse position for six to ten years. Seventy-one percent of the participants held the charge nurse position on average a quarter of the time weekly, and 14% held the charge nurse position either all the time or half of the time during the week.

Participant's Work Details

Participants reported being a charge nurse of units with a mix of care (intensive or step-down) and patients (adults or adolescents) provided. Intensive care units were defined as units where staff may need to manage patients with potentially aggressive behaviors or the highest degree of risk and need for containment regularly (Wynaden et al., 2001). Step-down units were defined by patients with behaviors or diagnoses that did not require more management or observations. Forty-three percent of the participants oversaw an adult unit with a mix of intensive and step-

down care; 29% an adult, intensive care unit only; 14% an adult, step-down unit; and 14% an adolescent unit. Fifty-seven percent of the participants reported managing more than five other staff members (e.g., other registered nurses, licensed vocational nurses, mental health workers, health technicians), while 43% reported managing three to five staff members. See Appendix C for the tabulated format of sample demographics.

Thematic Analysis: Two Critical Themes

Two themes emerged from this study: *social-cognitive preparedness for the ever-present threat of crisis* and *effectively responding to interpersonal and intrapersonal conflicts*, with each theme consisting of several sub-themes. The first theme reveals the skills of charge nurses in this setting that help prepare them for the unpredictable nature of their work. The sub-themes include administrative issues and challenges, the bridge between management and the unit, assignment/delegation, patient care, patient advocacy, establishing a connection with staff, knowing your staff, and providing guidance and mentorship to staff. The second theme reveals the conflicts that arise for charge nurses, personally and with staff. The sub-themes include interpersonal conflict between charge nurse and staff, intrapersonal conflict, and coping with interpersonal and intrapersonal challenges. The following two paragraphs will provide an overview of each theme, followed by separate sections with in-depth descriptions and exemplar quotes for each theme and sub-themes.

The first theme explores how participants utilize their professional roles and relationships to mitigate unit safety. Participants provide examples of how they develop these relationships amidst their responsibilities, specifically focusing on the connections between participants and staff as they work in a team to provide patient care. These connections begin with professional encounters where participants first learn about their colleagues' work-related capabilities, skills,

and limitations. As they go through experiences together, participants develop a deeper understanding of staff's conscious and unconscious experiences that influence behavior. For participants, understanding these professional layers of their staff can facilitate or inhibit teamwork, which has safety implications.

The second theme explores the interpersonal and intrapersonal conflicts participants face in the workplace. Most conflicts occur between staff, as they work intimately with each other, and were mainly seen in their differences of opinions and inconsistencies in care. In addition, the context of an unpredictable work environment, overwhelming and unexpected workload, and less-than-ideal working conditions (e.g., staff shortage) further complicated these conflicts. Participants describe situations wherein they must manage conflicts, in addition to their administrative and direct patient care responsibilities, and generating negative repercussions that can degrade both their self-esteem and their professional leadership abilities.

The two critical themes reveal participants' experience of navigating constant human interactions as a means to build or maintain team cohesion, which is imperative to preserving unit safety (Fourie et al., 2005). The interpersonal relationships and conflicts experienced by participants create a foundation of knowledge about their staff and team. This information served helpful for the charge nurse, especially in situations where they must make quick and critical decisions to maintain safety.

Theme 1: Social-Cognitive Preparedness for the Ever-Present Threat of Crisis

As the unit's frontline leader, participants utilized their administrative, patient care, and staff relationships to shape the workflow of their shift. They prepare for the unpredictable nature of their work, considering how their decisions and interactions influence the unit, patients, and staff's safety.

Administrative. Participants started off identifying their charge nurse role according to the administrative and managerial technical skills shared by their medical counterparts:

> "coordinating activities on the unit, assigning work to the nursing staff in the unit, instituting/implementing emergency procedures as necessary, communicating patient status to oncoming nurse shift and providers such as psychologists, psychiatrists, social worker, therapists, sometimes case managers in the past, and nursing management; educating nursing staff on patient care as necessary, supervising the delivery of care in the psych nursing unit as charge nurse" (Participant 5)

Also,

> "We're responsible for looking at the staffing for 24-hours to make sure that we have proper coverage for the unit." (Participant 6)

Having an overview of the unit's activities into the next 24-hours allows charge nurses to adequately staff other shifts. Since their team consists of a mix of licensed (e.g., registered nurses) and unlicensed staff (e.g., patient care support specialist) with varying scopes of practice, participants must consider how to utilize their personnel accordingly. For instance, charge nurses of these units consider how much "movement" occurs on each shift:

> "there's always stuff that's moving that sort of organizational-type of things, and so keeping track of all of those things so that—and knowing how to prioritize what are the really important things." (Participant 7)

Their all-encompassing role consists of coordination, delegation, communication, education, and supervision of the team of staff based on the individual and group needs of the patients and the unit. These also assist charge nurses in anticipating the staffing needs of their shift and other shifts.

The Bridge Between Management and the Unit. Participants' direct oversight and involvement with staff and patient care provide them an impression of the unit, staff, and patients. They become the bridge to nursing management, as they are.

> "…responsible for reporting back to management and house supervisors about what the acuity of the unit is, how many admissions they get, how many discharges they're working on, trying to navigate with intake department on—we are short today, we don't have a nurse to do that 3rd admission that you're trying to give us when we're already short, trying to get the house supervisor on board with that". (Participant 3)

They hold themselves responsible for ensuring the workflow is doable and safe, and if not, sought out their resources (e.g., management) to troubleshoot:

> "There's multiple charge nurses on the unit. So, these issues get brought up to a managerial level because the charge nurse's responsibility is trying to communicate this and try to relay this information. And when we're on the same page in report, and then we leave and things aren't being followed through, and it reaches a point where it's out of the charge nurse's hands, the charge nurse's next responsibility is to escalate it up to management to try and get some type of corrective action and corrective game plan in place." (Participant 4)

As the charge nurse, participants must know their role limitations and when to seek out nursing management. For instance, participants exchange patient information with staff and charge nurses from other shifts during hand-off. At times, this can provoke differences in opinions between shifts. Under conditions such as these that require a resolution or middle person, charge nurses can seek out nursing management's assistance. By understanding their

limits and their resources, charge nurses can prevent further escalating-an issue between staff or shifts.

Assignment/Delegation. Participants assumed responsibility for the patient-nurse assignments and task delegations to accommodate safety. One factor the participants considered during this planning phase is:

> "a patient's acuity—it usually tells you how the unit's the busiest and how all the stuff are factored in. The higher acuity is, the more it takes from the staff to be more attentive, to make sure everyone is safe, and everyone's expected extra help if we need extra staff. So, it's more factored in on the safety perspective." (Participant 3)

However, the constant movement of staff and patients required them to adjust the assignments multiple times a shift, as

> "The staffing needs can quickly change in the whim of a second depending on what's going on with a patient or patients in the unit." (Participant 5)

Based on the needs of the unit, it could be the case that the charge nurse also must take on staff nurse roles to maintain safety:

> "…the charge nurse at this time, will support the other needs of the unit. Maybe he or she can do rounds for half an hour until they find other means to replace the staff, or I can reassign other and delegate other tasks to make sure that that person's role is being covered in safe way and consequently, for example, my charting might have to wait for a couple hours so that I can readjust the schedule, the patient's needs at that moment, the entire unit's needs at that moment." (Participant 4)

Reassigning and redelegating tasks to appropriate staff becomes especially crucial in critical situations that threaten unit safety:

> "… you should be able to have a quick grasp of what's going on in the unit and being able to quickly, promptly, immediately step up to the plate if you're needed to, by rearranging the tasks that has already been delegated to the nursing staff are needed to assign them or direct them to do emergent care." (Participant 5)

These last two quotes reveal the length at which charge nurses will support the safety of the unit. Despite the time and being pulled away from their other responsibilities, they must be flexible in responding to the unit's needs, whether they involve themselves directly or delegate tasks to staff appropriately to the patient's care.

Patient Care. As the charge nurse, participants assigned themselves, patients, of which they are responsible for providing care, evaluation, documentation of their symptoms and condition:

> "… making sure that we're reviewing all the labs for the patients and everything's within normal limits, that people are being compliant with medications, or updating doctors if they're not, monitoring for side effects of medications, and/or behaviors and monitoring how effective coping skills that we've been teaching our patients, how effective they are at utilizing them." (Participant 1)

Although other staff assisted the charge nurse's patients with their needs, this could not replace the benefits of directly involving themselves with their patients. This allows the charge nurse to develop trust and a therapeutic relationship with them, understand who they are outside of their diagnosis, and tailor their care to their needs. Although their other responsibilities compromise this aspect of their role, these relationships seemed beneficial as a team leader in a crisis situation,

"…by taking that extra time to deescalate this patient and try to get to the point where they don't have to be held down to get medications, where they can try and utilize some coping skills and be cooperative with taking medications orally, just to help bring them at a level where they can manage it a little better and use those coping skills that we're trying to teach." (Participant 1)

As the team leader, charge nurses have the final say on when and how the rest of the team will intervene with the shared goal of bringing the escalating situation down to safety. In this example, this participant valued the extra time to talk an escalated patient down to a calm state to negotiate on an appropriate level. If done successfully, charge nurses and their team can still salvage the trust they may have built with the patient. If the situation continues to escalate, charge nurses are still conscious of how the proceeding interventions will affect the nurse-patient relationship,

"I want to make sure that this patient doesn't come back after taking medication and totally distrust the entire unit, so that's why I focus a lot on that rapport building." (Participant 4)

Patient Advocacy. Participants described their role as a charge nurse as being an advocate for their patient between other health care providers and nursing staff. This means taking information from the patient and other staff and constructing a more accurate picture of the patient's behavior or symptoms:

"And so, my job is to make sure that I advocate for the patient and present what's been actually happening with the patients. Because I know, when I have an interaction with the patient, my interpretation of how they are definitely changes when I observe them interacting my peers or with some of the floor staff. And when I have a floor staff come

up to me and say, ‘hey, you know, so and so's acting weird’—even when I talked to them, they weren't acting weird—I definitely trust that, their perspective. And so I feel like that's a really important part of my role is to make sure that the doctors are aware of things that are that are maybe not seen in a 15-minute interview with the patient.” (Participant 7)

The charge nurse's voice is also crucial in this setting, considering some patients cannot communicate their needs (e.g., their psychosis inhibits their ability to speak coherently). As a member of the patient's treatment team, charge nurses can advocate for interventions or treatments amongst the treatment team, who mainly consist of clinicians (e.g., psychiatrists, social workers):

“I like feeling like I personally have a voice in the treatment plan for these patients, and I'm going to speak up during the treatment team with my perspective.” (Participant 7)

Establishing a connection with staff. In the charge nurse role, participants spoke about navigating dynamic interactions with their team members in critical and non-critical situations. This "navigation" consists of familiarizing oneself with each staff's work-related skills, capabilities, and limitations and ~~is~~ established through constant interactions in everyday work. For instance, staff interactions and their effect on unit safety are exemplified through participants' accounts of crisis events. These are situations involving patients who either are escalating or has escalated in unpredictable behaviors to the point that staff must act:

“…we will have a code word that we're familiar with, whether it be ‘T-shirt’ or whatever, and at that time, we go into our positions—which is one hugger, two hangers, and then another person making sure that as we bring the patient down to the ground, that we're going to safely under, monitoring the patient and the staff and make sure that we’re doing

all this safely… but when you work with the same team repeatedly—like we've been fortunate to do on our shift—you get to know each other's facial expressions. So, you know when to do certain moves. If I give somebody a cue with my eyes, they know what to do." (Participant 6)

This example illustrates when having an established connection with staff can be beneficial. There are subtle moments during these situations that can change the course or outcome of the interaction. To best handle them, participants and staff need to be in sync, including verbal and nonverbal dimensions, a shared understanding of each member's role, and an ability to use the team's inter-connectedness and trust to respond. This is vital in situations that require abrupt action and permit minimal communication amongst care team members – for, without an established connection, individual and group safety can be threatened. For instance, a subtle cue by the charge nurse that is not well-understood by staff within the team can result in the wrong or lack of actions that can be detrimental to the team's safety.

Knowing your staff. As noted above, emergencies are frequent in inpatient psychiatric settings. By definition, they are unpredictable, and they force participants to make quick decisions, to deescalate in a timely manner safely. It is in these moments that a charge nurse's understanding of the staff's skillsets is crucial. Participants spoke about how they must consider the variability in patient condition and staff comfort level and abilities when responding to emergencies. If either appears incompatible with the other in a given crisis, negative consequences could ensue:

"…something overwhelmed her and triggered her about it. She came out, the more strict staff member was out in the milieu and he said to this patient, 'Hey, why are you leaving group?' And she turned to him and screamed at him and cussed him out for (*laughs*) no

> reason. And he's like, 'No, you need to go to group, or you need to go into your room.' And me, as the charge nurse, knows this patient and knows that she's not going to respond well to those limits and knows that if my staff member tries to go and put on that demeanor, it's going to make stuff worse and it's going to escalate our milieu. It's going to make all the other kids all frustrated and try to defend her and all this stuff."
>
> (Participant 1)

Note that, given the impact this single event could have on the entire unit, the participant had to act. Although one patient was affected, negative interactions between staff members can provoke other patients, challenging the sentimental order of the environment, creating compounding risks and uncertainties. This potential makes managing safety more complicated than it may otherwise seem because, among other things, it requires that staff deescalate an entire unit rather than one person. The potential for compounding emergencies further illustrates why participants must form reliable judgments about staff's skills essential to addressing escalating patient behaviors.

This quote also illustrates an obvious corollary, that the charge nurse should understand each of their staff's limitations in each situation. This knowledge is essential when planning courses of action and assigning tasks to prevent putting anyone in an unsafe position. Also, understanding staff limitations can elicit proactive responses to help them improve these areas, such as providing training, education, or practice with constructive feedback and encouragement from the team. For example, some participants provide examples of how they plan to train staff in hypothetical situations that would require the team to work together. From this, areas for improvement were identified, based on how safe it would have that staff in conditions that pose a risk for harm for the staff, patient, and the unit.

Providing guidance and mentorship to staff. Participants also commonly shared examples of connecting with staff through guidance and mentorship. This involved acknowledging the differences between views and providing both parties the opportunity to be heard and, crucially, understood on their terms. For one participant, this was seen when addressing a staff person's way of reinforcing the unit's protocols that were deemed incompatible with a patient's condition and behavior:

> "…she's confused, she's going to be weird and kind of loopy today. She's going to flip out on you so try to just give her space. I know that we're being really strict with this masking thing and it's important, and you're really doing a really awesome job at making sure that they are keeping it up… we don't want to spread his disease, you're amazing for that. But try to just stay away from that kid and let other staff members intervene, because I don't want you to get into power struggles with her today 'cause this is how she's going to be. And he's like 'oh, oh that's the kid? That's the kid that's going through this?' I'm like, so you just need to focus on being a little bit extra nurturing and little bit sweeter to her and more understanding. Don't be so strict and firm. She's not going to respond well to it. And he's like, 'oh, ok'. So, he was little bit better. It helped a lot because she's not very stable." (Participant 7)

Sharing information with staff and offering suggestions on addressing a patient's condition and behaviors prevented unnecessary consequences between the staff and patient. Naturally, some discussions can be taken the wrong way by the recipient, such as criticism. However, as this quote shows, by acknowledging the staff's intention for setting boundaries and enforcing rules, the participant showed respect for how the staff person may feel with this type of discussion, where, absent the respect, it could make them feel bad or take the advice as personal or

professional criticism. Forming respect, and using this respect as a basis of communication, strengthen the relationship with staff that benefits the team.

Another approach to connecting with staff during difficult or uncomfortable conversations is by providing the opportunity for both parties to be heard:

> "I had a staff member who did something very un-therapeutic with a patient, and I talked to him about it and he said, '[participant's name], I have been accused of sexual harassment on a patient, and I am so aware of that and I am not going to do what you asked me to do, even though you've asked me to do it in the name of safety, because I don't want there to be any possibility that I could get accused of this again'. So, I had never even considered that perspective—that the reason that, you know, within arm's length of the patient or didn't enter the patient's room, was because they were worried about being accused of doing something improper. And so, it was helpful for me to have that information." (Participant 7)

In this example, two layers of safety surfaced. The first is the risk to the patient's safety due to a break in protocol, which the participant addressed. In this case, the patient was deemed a high-risk for harmful behaviors requiring the designated staff to be a certain distance from them. This would allow staff to intervene in a timely manner should harmful behaviors emerge. The second layer of safety referred to in this quote is the staff's fears (i.e., false accusations from past experiences) that threaten their safety and job security. Providing the staff an opportunity to share their perspective gave the participant a different view that they would not have considered unless they spoke with them. This alternative perspective gave the participant the ability to immediately address both patient and staff's safety in an alternative way.

This example shows a development of a deeper understanding of this staff's capabilities through communication and active listening. For the participant, it informed a change in patient assignment during that time and future assignments for that staff person. Decisions like this can generally help staff feel safe and capable of doing their job and feel their leader will listen and consider their concerns. Although there are situations where such accommodations cannot occur, having open-ended communication helps participants assess alternatives to interventions and assignments.

As participants form a deeper understanding of their staff's professional qualities, they develop an understanding of their potential. Participants provide staff opportunities for their enrichment and growth that contribute to the team and patient care. These were seen when participants shared aspects of their leadership. Although they understood the ultimate responsibilities of outcomes rests in their hands, they did not appear to see themselves as the unit leader that needed to be followed all the time. Instead, they described wanting their staff to feel involved in the patient's care by empowering them to delegate and plan amongst themselves the tasks needed to be done.

Some participants actively found ways to tap into the staff's own motivation:

> "…Even the PCSS [patient care support specialist]—something *I'm* trying to empower them by giving them once a month a policy, so they can educate themselves and use it to their advantage… having the ability to decide on their own to do what's needed to get all these things done... I want them to feel involved, not because they're just a PCSS, that they would just follow to whatever I tell them, to whatever the nurse told them—but something that's really good too, that they're planning on their own. They're actually able to have that turn of empowerment…there's more a sense of fulfillment knowing that they

> can make that decision on their own, where I don't have to assign them their breaks, and who do this, and do the other responsibilities that they're expected to accomplish within that shift." (Participant 3)

This example illustrates how this participant empowers their staff to take ownership of their responsibilities with education and action. Beyond the staff's professional duties, the participant hopes to tap into the staff's individual internal motivation to create a sense of fulfillment. When a staff takes ownership of their responsibilities, they are held accountable for the consequences, influencing how they make decisions. Having this ownership on their responsibilities can have an impact on the staff's satisfaction with their job. These opportunities allow staff to apply their knowledge and make decisions that impact not just themselves and the patient; but also the rest of the team.

Building relationships with staff appear to be especially valuable when working in an inpatient psychiatric care environment. Although it does require more time and effort for the charge nurse, these efforts can have long-term benefits in making an unpredictable atmosphere more manageable:

> "The nurses that I work with, we already know what to do, what not to do, when to do, because we work with each other so well and we know when to take our breaks, we know exactly who goes when, what every day and that's the consistency, the connection I think, what we have that keeps us together." (Participant 4)

Further benefits of developing a more profound, personal understanding of staff include staff being less resistant to being told what to do and the development of camaraderie that enables them to work together towards a shared goal.

Participants' accounts of their experience suggest a moral obligation to their staff, especially concerning their duty to provide for their safety. Although they understand the legal ramifications of safety failures, participants' accounts conveyed a sense of higher (or deeper) obligation to their staff's well-being – often by speaking about putting staff needs first, despite having an overwhelming workload and being pulled in different directions. Indeed, participants seem to constantly consider their staff's workload, specifically assessing if the workload at any given time is manageable or not. If not, participants would take the initiative to take on more work from the staff, reach out for additional institutional resources, or reprioritize non-patient care tasks at the expense of not completing their workload or staying over to finish it. Participants communicated through these actions the importance of the staff to the charge nurse role, the team, and the unit safety – and in turn, were communicating the value of each staff member and the work they put in. This has implications for the working relationship and the team, such that it engages them in a way that facilitates the workflow and teamwork. It allows staff to feel a personal sense of purpose that they contribute to the team's efforts in their goal of safety.

Theme 2: Effectively Responding to Interpersonal and Intrapersonal Conflict

This second theme provides an understanding of the patterns in the participant's responses in this study to conflict. Human conflict is a constant and ever-present feature of inpatient psychiatric care. Some conflicts evolve naturally from daily and intimately working with staff. Others develop from conflicting motivations or uncertainty about the best course of action to take in any situation. But the most crucial point is that these conflicts become relevant to understanding what it is like to be a charge nurse when they impair the team's ability to maintain its professional effectiveness.

Interpersonal Conflict. For example, interpersonal conflict becomes a specific concern worth noting when the disagreements become severe enough that team members feel personally attacked and thus become a risk for loss of team cohesion. One participant describes her experience as a charge nurse when deciding on interventions during a crisis:

> "…There are people who really believe strongly in IM [intramuscular] medication and I think that it's for the sake of convenience most of the time, and I don't really agree with it. And so, to go from the culture of wanting to constantly give IM medications as an immediate response—it definitely feels like I'm stepping on the toes of the people who are constantly telling you to get the IMs ready, just from other RNs who might feel it might be more necessary to give the IMs." (Participant 2)

This excerpt reveals the conflicting views on intramuscular medication in crises shaped by a subculture of beliefs that can be difficult to persuade. Participants in time-sensitive matters find themselves under pressure before deciding. For example, this participant may choose the least restrictive measure if they feel intramuscular medication was chosen out of convenience to the staff. Having to make an unpopular decision can result in staff criticism and judgment, especially when the outcome is undesirable. On the other hand, the participant may proceed with the team's recommendation if they are outvoted, even if it may not seem beneficial to the patient. This can challenge participants' morals/ethics surrounding patient care, resulting in feelings of guilt or even judgmental self-deprecation.

The differences in beliefs and experiences in psychiatric nursing have also resulted in patient care inconsistencies between staff and shifts. When participants are aware of these differences, they can work towards resolving them. However, leaving differences unresolved –or even just unacknowledged – can create tension between staff that begins to impact patients care:

"We have the kids go at times from being cooperative to snapping and trying to yell at staff on AM shift because they're like, 'you guys just are too controlling. PM shift doesn't have a problem with this. I did this on PM shift. I'm restricted to my room on PM shift, but they took me off the unit to go to play in the gym, and you're saying you can't play in the gym 'cause I'm restricted. What is wrong with you guys?'. It makes patients angry, patients yell at us. We're a psychiatric hospital trying to provide a therapeutic experience for patients. If there is conflict between staff and no consistency and no follow-through, it causes drama from our patients towards us. It causes work frustration from our staff to our other staff. So, that's what I mean when I say if there's conflict between staff, it breaks down everything. And it goes down to the level of care to the patients. The patients are now angry. If you're angry and emotional because a staff member is setting a different limit and there isn't consistency in an environment where you're supposed to provide consistency and teaching anger management and teaching emotional regulation—what are you doing? Like, what are you doing?" (Participant 1)

This is an essential set of observations because it illustrates how the interpersonal conflict between and among staff can spill over into interactions with patients, where it can cause more significant problems that affect people beyond the source of the original conflict. In psychiatric nursing, staff are the providers of safety and security in patient care. When group and individual dynamics threaten that, patients can feel additional anxiety and frustration on top of their psychiatric conditions. This can leave them feeling uneasy, unsafe, or insecure. For instance, being hospitalized in an environment is supposed to provide certain types of care can dampen the trust in their nurses. They may feel deprived of the utmost care and support from staff, creating a

nontherapeutic atmosphere for the patients. Nevertheless, these situations can be prevented by identifying nuances early:

> "…As a leader you should be able to recognize and be able to address right away. Otherwise, the situation can escalate… if one staff does not follow the guideline but the other staff is following the guideline, then there will be inconsistency of care and therefore, it creates a challenge as well…" (Participant 5)

Between Charge Nurse and Staff. Interpersonal conflict can also arise from the charge nurse's beliefs about how they view their staff that can have a personal effect on them. One participant, who was not assigned charge nurse that shift, shared how their charge nurse peer had affected them:

> "…But the charge nurse said, 'I don't care about the feelings of the staff. I care about advocating for what's best for the patient'… and I was, like, man, that really hurt my feelings and I felt really angry and I had a hard time sleeping and I can't believe you feel that way… I don't feel that way. I feel a responsibility towards my coworkers and making sure that they are not—that they're viewed as important." (Participant 7)

Note how this participant links her team's effectiveness to its ability to minimize interpersonal conflict, thereby ensuring safety. This quote illustrates the deeper consequence of neglecting the emotional reality of the team members, which can include suppressed anger and resentment, which can contribute to interpersonal conflict. Although nurses' line of work revolves around patients and their care, the participant did not believe it should be at the expense of disrupting their colleagues. Participants felt acknowledging the feelings of their staff was essential to heading off interpersonal conflict on the team, which in turn contributes to the culture of teamwork and safety:

> "…If someone is really frustrated with something—because it seems like frustrations are a lot of the times that people might end up being less safe, because they're frustrated and so then they try to disassociate themselves from what's going on, 'Well, I don't care then I'm just not going to—', and that kind of attitude ends up being unsafe. If you're not—if you don't care, then that's not safe." (Participant 7)

Participants that share this insight understand the impact of the feelings of staff on their work ethics. It elicits a domino effect where the staff's frustration can grow into a nonchalant attitude that leads them to mentally or physically remove themselves from the situation. Allowing this to continue can result in staff feeling or exhibiting dissociative behaviors that threaten the consistency of care and teamwork needed to provide for the patients and unit safety.

Interpersonal conflicts can also arise from charge nurses' management and approach that negatively affect the staff relationships. When working with staff, participants experienced staff's receptivity or resistance based on how they were treated. Illustrating this, one participant shared their insight about the subject:

> "—If your staff members feel like you don't manage your emotions or you're rude or you don't have a grip on the unit, they will not respect you. They won't, and they'll blow you off and they'll get into power struggle with you as a charge nurse and it'll become a situation where you're like dude, I told you to do this. This is my responsibility I'm delegating to you. You need to do this. And they're like, 'no, you don't get to talk to me like that'…'Cause when you have staff conflict and you're trying to manage a milieu of psychiatric patients—dude, you're set up for failure. It's not good." (Participant 1)

This example reveals the importance of staff relationships to the position and team leaders' behaviors that hinder it. When charge nurses delegate assignments and tasks, they are

still accountable for the outcomes. However, their relationships with staff can make or break this process. For example, if the charge nurse exhibits negative or problematic behaviors, staff become more resistant, lack confidence, and lose trust in their leader. Charge nurses must have self-awareness in how they affect their staff and strive to improve these areas.

The importance of addressing interpersonal conflict with staff shows in the influence of the team dynamics and work environment:

> "…When people are not on the same page for that team approach, it really becomes hard to create a good and fun and safe and good-feeling milieu, therapeutic milieu is what I mean. It becomes hard to make decisions—what I mean by that is, what I was saying earlier with like make those tough decisions while other people disagree." (Participant 2)

Intrapersonal Conflict. As the frontline leader and representative of the unit, participants carry great responsibilities and liabilities to provide for their staff and patients' safety. This can create inner conflict for the charge nurse, as they grapple with the work-related pressures and personal struggles in the role, which makes it difficult to decide a course of action. Participants shared situations during their psychiatric career where they experienced ambiguity that affected their ability to lead. These ambiguities sometimes resulted in participants having to make decisions that also compromised staff and patient safety. For example, one participant felt specialized training required by all staff only provided for ideal situations, leaving them feeling fearful about the outcome of its application in practice:

> "…And at the same time, some interventions really doesn't work in situations where it has been taught on how to do that intervention, because [it]… has been taught in an ideal situation. Or even if we do that intervention, but it doesn't really happen that way all the time. There are several—for instance, the intervention was taught and staff had been

trained on doing that PMDB in a patient—that you can easily perform that physical hold, whereas in the reality, it's not always. And I would say even most of the time, that a patient is somebody that you cannot easily implement what was taught in that training simply because either they're in a corner of a room and you cannot easily grab them, or there's with some obstruction, like a chair between them or table between them. And not all you can safely perform that, and unfortunately you cannot wait for that patient to be in a good situation that you can easily grab the so that you can effectively perform that PMDB" (Participant 6)

This excerpt illustrates the participant's struggle in relying on specialized training techniques in high-risk situations involving staff and patients. They experience feeling unprepared to make a critical decision or modification without the appropriate supports for the next course of action. At the same time, the decision not to act poses a safety issue with the situation unhandled. This can leave participants feeling they are risking the staff's safety and the patients as the outcomes fall on their shoulders. If their interventions are ineffective, it could result in injuries and legalities, placing undue pressure and guilt on the participant.

The participants' ambivalence also applies to non-crisis, general psychiatric interventions. When compared to their medical counterpart, the outcomes of psychiatric interventions still varied:

"I always also say being a leader and having patients with mental health is still totally different sometimes compared to med-surg floor patients where you can—there is already been a lot of studies with those patients. Blood pressure this, you give this medication. For sure you know the blood pressure will go down… But in a psych facility, there's a problem you really don't know. Everything is still experimental; everything is still more

of a ‘let's wait and see’ kind of thing. Still, not one intervention is not at all in general with a cure or help the patient right away… But in the psych, sometimes you cannot really tell what the patient's going through..." (Participant 6)

This "experimental" feeling can be challenging for charge nurses in this setting to plan actions and delegate tasks to their staff. Even if the charge nurse has an idea of the interventions and treatments appropriate for the patient, they must often reevaluate to see if those interventions are still applicable at that time. The individuality of each patient further complicates the difficulty in not knowing the outcomes of established interventions:

"Each situation could generally look like the same, but each patient are unique and have their different behaviors and you really wouldn't know what's going on with this specific patient and how this patient can be deescalated, if he could be or she could be deescalated at all." (Participant 6)

The ability to apply generalized psychiatric interventions to each patient's uniqueness can be a challenge for participants. It requires time and being actively involved in understanding their uniqueness and developing a therapeutic relationship. This is challenging in the inpatient psychiatric environment, where there is a shortened length of stay. For participants, this time is reduced between being a leader, their administrative obligations, and providing direct care with their patient assignments:

“… It’s a pretty big, all-encompassing role because we do have a lot of managerial things that we need to account for, but we’re also expected to manage secretarial and by manage, I mean do it all and take on full patient loads which can stretch us really, really thin at being able to connect or engage with our patients and truly understand what

they're struggling with. And I think that being under that level of expectation really takes away from a therapeutic engagement or process with the patients." (Participant 1)

For some participants, this can be overwhelming as they make decisions that put themselves, patients, and staff at the forefront:

> "…To come into a psychiatric unit and then have somebody screaming and yelling in your face, and being able to know how to handle that and know how to stay calm—it's scary. It was scary for myself when I transitioned 'cause I'm no longer just a person that's going to administer the medication; I'm the person that's responsible for the unit right now, and that in itself is scary. It's a higher level of responsibility—afraid that you might be something wrong, that could end up getting somebody hurt, that a patient could end up getting hurt because you didn't make the right call at the right time." (Participant 7)

The weight of responsibility this participant feels is related to decisions they make that affect others' safety. It is a fearful and anxiety-provoking feeling for participants to know that their safety and security reside in their hands. Although there is research on psychiatric interventions such as seclusion and restraints, there appears to be a lack of research in other aspects of psychiatric nursing that need attention. Nurses who assume the charge nurse position should rely on evidence-based research to inform their practice and interventions instead of feeling experimental. This obligation gets put at the forefront of everything else when faced in situations where it is threatened. However, over time, the pressures of this position can leave a profound effect on the individual as they face situations that affect them personally.

Coping with Interpersonal and Intrapersonal Challenges. Participants shared internal ways to deal with the challenges by changing their perspective to something more attainable,

pursuing self-care activities, actively listening, and acknowledging the differences in opinions. Despite these challenges, participants work through these personal challenges, usually motivated by the knowledge that other staff and patients relied on their leadership and were at risk if they did nothing. Participants spoke about how their outlook on their leadership position inspired them to be proactive in an unpredictable work environment by constantly assessing and evaluating situations and relationships through the lens of safety:

> “Everything is always safety-focused for me 'cause that stuff, if you don't look at it that way, that's when bad things happen. And you can't prevent everything—like, who knew that guy would slam his face into the wall, I mean, who knew? You can't prevent some stuff from happening, but now that we know, we're going to kind of hang out with him a little more.” (Participant 5)

Participants also developed their professional and leadership identity that shaped their approach. This includes having an idea of their own beliefs and philosophies of care:

> "…At the end of the day, what I care about is that my patient is being advocated for. I would much rather advocate for this patient to take a PO [per os] who has a history of sexual trauma, then to have to escalate it to getting to holding them down and giving them an IM. Even if there is tension between other staff members and the decision making of it, I still feel that as long as the patient is given the best opportunity, then I think it was the right decision…" (Participant 2)

In staff disagreements, it was also helpful to communicate their opinion as a way to cope with residual guilt or consequence if their idea could have made a difference:

> "Generally, I can't live with myself if I don't at least say something, say what my gut is telling me, and so I will try to say it, even if it's kind of baseless and it's just a gut feeling, I still try to say it." (Participant 2)

As a charge nurse, participants developed a different way of looking at their position to cope with the harsh realities of nursing:

> "…Just in balancing that separation and realizing that as a nurse, that you can't fix everything and you can't control the outcome of everything. Because you're one human being and there's so many other things that need to be set up in place, but being able to focus on the fact that you're kind to somebody and help them out in that moment and hopefully they carry that moment with them and think about it sometime later on…" (Participant 1)

Participants adjusted their outlook as a charge nurse to what is attainable and manageable in their line of work to manage the everyday stress. Considerations of safety, being so paramount in the mind of charge nurses, function as a mental "tie-breaker" – whenever there is intrapersonal conflict, the quick and practical way of "getting around" the conflict (rather than resolving it) is just to do whatever either is most safe or has the least amount of apparent risk.

> "I've become a lot more comfortable with figuring out which of those [responsibilities] are the most important thing and, and really prioritizing those things, and which things I'm comfortable saying, well, this didn't get done and I'm going to delegate or pass this on to the next shift. Things don't stress me out as much anymore." (Participant 7)

This means that charge nurses, in order to be able to moderate their own personal conflicts and responsibilities, need to learn how to see and constantly be aware of the "bigger picture" of how the ward is functioning at any given time. This may help while working in this setting where

unpredictability and grey areas exist and research is ongoing. This offers an alternative to any high or unrealistic expectations some nurses put on themselves; figuring out to what extent one can do for a patient in their current setting can be a start, especially for new graduate nurses or nurses who enter a different specialty in their career.

Analysis Summary

The study's findings reveal the complex nature of human relations that participants as charge nurses must navigate and their administrative and patient care responsibilities. While the interventions and treatments are centered around the patient, participants spoke in meaningful depth and length about their interactions and conflicts with staff, both of which appear essential to managing a team. This focus does not seem to be explained because leading a team of health care providers that can effectively work together falls on the hands of the charge nurse. As participants shared, the context of trying to maintain unit safety seems to influence the relationship between charge nurses and their staff strongly.

The participants in this study take proactive approaches in mitigating unit safety, but under the premise that their interventions are not a one-size-fits-all inherent to crises. As the team leader with the final decision, participants sometimes must adopt safe but experiential approaches to handle a situation quickly and safely. This has caused feelings of anxiety, fear, and guilt, along with the legal risks involved should it result in severe injury or accidental death. The findings suggest that psych charge nurse training could be useful in providing the tools that can be used to enhance and implement clinical & managerial judgment within the context of rapidly changing situations.

Discussion

The experiences of charge nurses working in an inpatient psychiatric unit that emerged from data analysis reveal how they navigate their relationships to preserve and mitigate unit safety. Charge nurses develop a connection with their staff professionally, personally, and through conflicts necessary for teamwork and patient care. The findings of this study provide a rich countervailing description of the charge nurse role in this setting. While not a comprehensive overview of their role, the preceding analysis provides readers a glimpse into how charge nurses' clinical practice and leadership influence team dynamics and unit safety.

Participants utilized a combination of competencies shared by their medical counterparts identified by Connelly et al. (2003b): clinical/technical, human relation skills, critical thinking, and organizational. However, charge nurses in the inpatient psychiatric setting emphasize human relation skills, which is not surprising as psychiatric nursing care is based on interpersonal relationships (Peplau, 1952). Connelly et al. (2003b) described human relation competency as a responsibility that affects the effectiveness of work relationships to accomplish patient care and other administrative duties (Connelly et al., 2003b, p. 301). The study's findings confirm how charge nurses use these skills in their practice, such as demonstrating care for others; dealing with difficult people, situations, and shifts; and motivating staff towards a common goal (Connelly et al., 2003b).

Compared to their medical counterparts, there are nuanced differences in how charge nurses in the inpatient psychiatric setting use these skills not only with their patients and develop a connection with their staff that enables them to work together as a team to provide patient care and safety. For instance, in critical situations, the charge nurse can give a subtle, behavioral cue to their team of staff to act in unison. For staff to understand what these cues mean, charge

nurses must first establish a connection and common understanding to minimize opportunities for patients to harm themselves and others (Kanerva et al., 2012).

Charge nurses may influence team relationships, but the internal motivators of each staff also play a role. Some participants recognize this and engage them with opportunities of empowerment with patient care. These are characteristics found under the research of transformational leadership styles, which are behaviors and attributes of individuals that help shape the organization's culture by empowering their workers (Bass & Avolio, 1993). This leadership style has been shown to positively affect staff nurse satisfaction and work environments (Casida & Parker, 2011; Manning, 2016). By developing their staff's sense of empowerment, staff may also cope better with the work stress (Rooney, 2009). These efforts could promote a strong culture of teamwork and help staff feel safe and secure (Rooney, 2009). However, research is still ongoing on the direct impact of patient safety and nursing empowerment, leadership, and teamwork (Richardson & Storr, 2010).

Participants also experienced interpersonal and intrapersonal conflicts with their role, which agrees with much of the literature (Kindy et al., 2005; Scozzafave et al., 2019; Shattell et al., 2008). In this study, interpersonal conflicts between staff occurred because of differences in opinions, beliefs, and attitudes about their work, patients, and the team. This is shared by Sherman et al. (2011), where charge nurse's sources of conflict include "differences among team members in values and beliefs about teamwork, loyalty, use of social networking, and preferred methods of communication" (p. 4). Deady and McCarthy (2010) also shared similar findings when participants challenged their peer's standard of practice, resulting in moral distress. Scozzafave et al. (2019) perceived interpersonal relationships as a work-related psychosocial risk

that, if not resolved, can affect the charge nurse's clinical decision-making (Deady & McCarthy, 2010).

Yet, participants provided insight into the humanized nature of their practice through their interpersonal relationships that may counter the conflicts they face. For the charge nurse, navigating interpersonal relationships constitutes learning about the professional qualities of each staff through open communication, active listening, respect, and acknowledgment. Hicks (2011) considers these as essential elements in preserving the other's dignity, which can be helpful in conflict resolution. It allows the charge nurse to better assess their staff's feelings to better address the underlying conflict source. By doing so, the charge nurse may resolve or minimize conflict earlier to maintain team cohesion. The offering of emotional support is especially crucial working in an environment characterized by unpredictability, aggression, and assault (Sobekwa & Arunachallam, 2015).

Participants also experienced ambiguity regarding psychiatric interventions and establishing nurse-patient relationships. This is consistent with staff seeing themselves in contradictory situations (Berg & Hallberg, 2000; Fourie et al., 2005). For instance, participants expressed frustration in developing therapeutic relationships with patients while also fulfilling their administrative and managerial duties. This is shared by others that felt non-patient-related tasks took them away from their patient's care (Delaney & Johnson, 2006; Seed et al., 2010). As a pillar of psychiatric nursing, therapeutic relationships with patients assist in creating a "safe, non-coercive environment" (Delaney & Johnson, 2006). However, charge nurse's inability to fill their therapeutic role (Fourie et al., 2005) is a consequence of the reduced time spent with patients (Glantz et al., 2019). Reduced time with patients as a result of non-patient care requirements contributes to the role conflict and job dissatisfaction psychiatric nurses experience

(Seed et al., 2010) and can lead to charge nurses feeling helpless, guilty, and frustrated (Deady & McCarthy, 2010).

Despite the conflicts, participants practiced proactive coping strategies in response to stress, such as training, reflection, and talking with peers. Individual coping strategies are especially recommended in the literature to mitigate situations of risk (Scozzafave et al., 2019). By practicing proactive coping strategies, charge nurses can better adapt to their job's demanding aspects and address conflict with staff. This could help explain the participants' balance of positive and negative outlooks threaded in their experience. In contrast to this study, individuals that utilized avoidant or dissociative strategies were more vulnerable to moral distress and had a more negative viewpoint on their role (Deady & McCarthy, 2010).

This study suggests the importance of charge nurses navigating relationships and conflicts as a preventative practice to maintaining safety (Fourie et al., 2005, p. 136). This aligns with a study by Delaney and Johnson (2006), who found certain staff behaviors, such as "becoming aware" of their internal feelings towards a stressful situation and deciding what to do with it, positively affected their efforts in creating a safe environment for all (p. 201). These are skills that can be utilized simultaneously with other de-escalation tools (Delaney & Johnson, 2006). However, staff relationships are not as heavily studied as interventions like seclusion as means of patient safety and risk management (Cowman et al., 2001; Fourie et al., 2005).

Working in a stressful environment threatens one's personal feelings of safety. Yet, as professionals, they have to care for their patients who are also experiencing their crisis leading to hospitalization. Thus, the patient connection and care are threatened when staff themselves experience internalized negative feelings for a prolonged amount of time (Delaney & Johnson, 2006). Staff is at risk for negative psychosocial consequences from stressful and violent

environments, also described as "pervasive invasive sequelae" (Kindy et al., 2005). The staff member experiences compounding adverse events that affect their work abilities. Participants provided examples of these behaviors as frustrations, dissociations, and withdrawal, which can have a domino effect on the team and patients. As is the case with charge nurses on medical units, charge nurses in the inpatient psychiatric units can foster conditions to help their staff through conflicts, such as feeling safe (Connelly et al., 2003b). Staff's feeling of safety can move them towards a sense of satisfaction, which is fundamental to staying in the profession (Kindy et al., 2005, p. 174).

Implications for Practice, Research, and Education

Further research and education about the leadership and clinical role of the charge nurse in the inpatient psychiatric unit are needed. This study suggests overlaps in the skills and competencies identified in the charge nurse literature (Cathro, 2016; Connelly et al., 2003b; Eggenberger, 2012; Krugman et al., 2013), but further research should investigate specific leadership skills to be effective in this setting (Eggenberger, 2012; Hanrahan et al., 2010a). Developing this body of knowledge towards a better understanding of PMHN skills, the scope of practice, and titling have implications for “workforce planning, funding for training programs, eligibility for stipend and loan payback programs, and opportunities for PMHN employment” (Phoenix, 2019, p. 45).

The overwhelming evidence that psychiatric nurses feel unsupported and disconnected from management and leadership (Shattell et al., 2008) makes a case for the charge nurse's role to be further investigated in this setting. For instance, studies can look at the impacts of charge nurse training in the psychiatric setting in the improvements in the areas of staff morale or retention. They are in a unique position as direct care providers and administration to lessen this

tension and create changes deemed important to direct patient care. For instance, they can be the voice of frontline workers with upper-level management, who create standards of practice but are removed from the realities of the unit (Hanrahan et al., 2010a). As frontline clinical leaders, charge nurses can be influential in shaping the inpatient psychiatric work environment (Connelly et al., 2003b). Further research can help support charge nurses in this setting by formulating a standardization of their role utilizing both research-based and practice-based evidence. This could also help with the role conflict they experience, lessening their moral distress.

Perhaps the charge nurse's role in this setting may also need to be reconsidered in the present time as they take on more responsibilities and a higher acuity of patients (Connelly et al., 2003a). Future studies could investigate ways to decrease the workload of charge nurses, so they have more time for patient care and staff mentoring, support, and management. In inpatient psychiatry, relationship-building and therapeutic communication takes time and an offering of oneself to be present. This is critical due to the uniqueness of the patients, as discussed in the findings and the literature (Berg & Hallberg, 2000). Charge nurses struggle with this and consequently may not form therapeutic relationships with patients. Future research can explore the perception of patients assigned to the charge nurse and non-charge nurses and the care they receive to determine any impacts it has on their care and outcomes.

As the future of the nursing profession, nursing students should be educated on the contribution to health care that mental health nursing provides and develop innovative ways to prepare them for new roles in mental health (Phoenix, 2019). Faculty and administrative leadership can provide evidence-based research to address the associative stigma that discourages students from this career path (Phoenix, 2019). In the clinical setting, charge nurses are in a perfect position to act as their educator, mentor, or coach (Connelly et al., 2003b;

Sherman et al., 2011). Their global view of the unit, interpersonal skills, critical thinking, and experience can influence students' perspectives and self-confidence. For instance, their exposure to the charge nurse role in clinicals may give them a broader understanding of what they do to support their inquiry, anxiety, or curiosity, compared to non-charge nurses who have a narrower focus on their assigned patients tasks (Sherman & Eggenberger, 2009). Raising students' awareness of this critical leadership role in inpatient psychiatry can encourage more to work in the specialty, further assisting in retention and recruitment (Phoenix, 2019).

Limitations

This study is not without limitations regarding the sample size, setting, and data collection methods. Although qualitative research does not aim to generalize its findings (Austin & Sutton, 2014), expanding sample size and geographical location may provide more information about the experience of the phenomena. Most interviews were conducted once with each participant, which did not clarify concepts found during analysis to ensure the primary investigator was interpreting based on the participant and additional insight into their world (Morse, 2000, as cited in Patton, 2019, p. 284). With this understanding, the researcher frequently reverted to the original transcripts and recordings throughout the analysis and reporting to ensure they captured the participant’s viewpoint. Additionally, follow-up on topics would help expand their thoughts and provide further insight ~~to~~ strengthen the data. Lastly, this study was conducted following the public health guidelines surrounding the COVID-19 pandemic. Thus, most interviews were conducted via telephone, which did not allow the researcher to observe any non-verbal communication (e.g., gestures, expressions). This could have been improved by using web-based video conferencing platforms, such as Zoom or WebEx,

to enhance the understanding of the phenomena and the process of interpretation and illustration (Denham & Onwuegbuzie, 2013).

Conclusion

The psychiatric nursing workforce is projected to experience a shortage of nurses as the demand for mental health services increases (APNA, 2019). In order to recruit and retain nurses in this setting, the different psychiatric roles should be fully understood (Cleary et al., 2011; Hercelinskyj et al., 2014; Redknap et al., 2015). Surprisingly, the literature is scant on charge nurses in the inpatient psychiatric setting (Seed et al., 2010). Although this role is heavily researched in acute medical settings, it may not be generalizable to all specialty settings without further evidence (e.g., bridging studies) because of differences known to exist (Eggenberger, 2012).

This study is one of the first in the United States that explores the charge nurse role, specifically in the inpatient psychiatric unit. Although charge nurses in this study share similar competencies and skills as others in acute medical settings, this study revealed the differences in how they use them. The study's findings contribute to the growing body of knowledge about the current roles and responsibilities of the psychiatric charge nurse in the ever-changing health care system (Berg & Hallberg, 2000; Cowman et al., 2001). Further research, as suggested above, could use this data as a starting point to the role of the charge nurse in the inpatient psychiatric setting.

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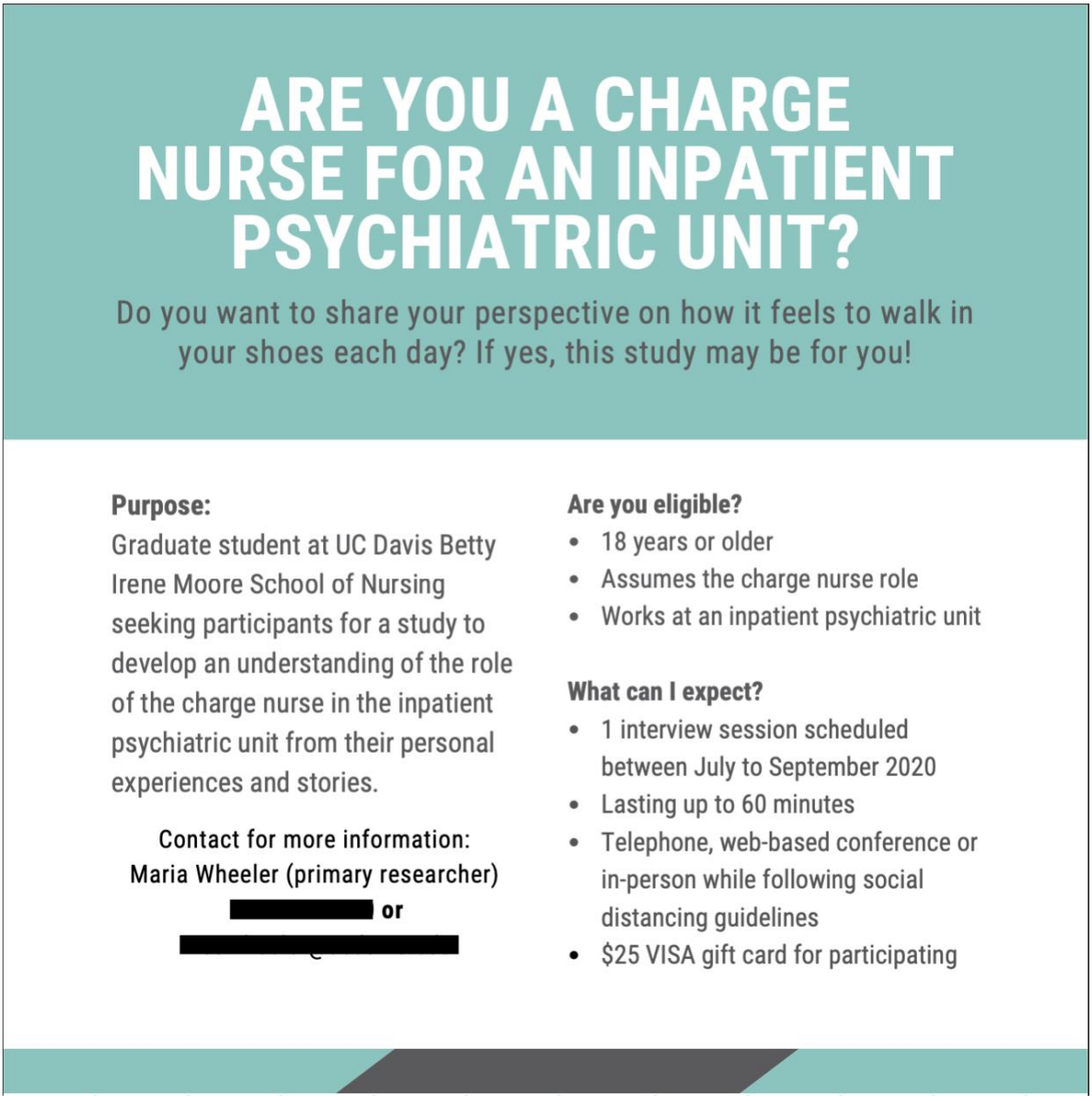
Appendix A

Recruitment Flyer



Appendix B

IRB-approved telephone screening script

Study Introduction
Thank you for calling to find out more about our research study **or** I am returning your call to provide more information about my research study. The purpose of this screening is to provide brief information about the study and determine if you are eligible to participate. My name is Maria Wheeler, and I am a master's student/researcher at the University of California, Davis' Betty Irene Moore School of Nursing. The purpose of my research study, "Exploring the Charge Nurse Role in Inpatient Psychiatric Unit", is to develop an understanding of the role of the charge nurse in the inpatient psychiatric unit from their personal stories and lived experiences. I will be asking participants to complete a brief questionnaire about their demographics then conduct an unstructured interview. This consists of the main question about what it's like to be the charge nurse on the unit, which may be followed by some prompting questions based on the interview for elaboration or clarification purposes. The interview will be audio-recorded. During the interview, I may take notes from time-to-time to refer to later. To protect your identification, no identifiers will be recorded. It will require one scheduled session which will last up to 60 minutes. These sessions will be conducted through telephone, Cisco WebEx app, or in-person while maintaining social distancing and face masks guidelines. Do you have any questions or concerns? With a basic understanding of the study, do you think you might be interested in participating? If No: Thank you very much for calling. [end call]
Caller is interested
Prior to enrolling people in this study, I need to determine if you may be eligible to participate. Do I have your permission to ask you these 3 questions? If No: Thank you very much for calling. [end call] If Yes: 1. Are you 18 and over? 2. Do you currently work at an inpatient psychiatric unit? 3. Have you held or do you currently assume the charge nurse position?
Post Response Communication
Based on your answers to the questions, you are eligible to participate in the research study. I will provide you an information sheet about the study. Your participation in the interview implies consent. We will also schedule a date and time for the interview. I will keep all the information I receive from you by phone, including your name and any other identifying

information confidential by storing it in a password-protected folder on my password-protected computer. Your identification throughout the study will be your given interview number and date of scheduled interview. Is there any further information you need about the study? [Obtain the potential subject's contact information]
Unfortunately, based on your responses, you are not eligible to participate in the research study.
Study Team Contact Information
Thank you for taking the time to talk with me today. If you have any questions or concerns, please feel free to contact me. My name is Maria Wheeler and I can be reached at [cell phone number] and/or [email].

Adopted from:
https://www.irb.pitt.edu/sites/default/files/TelephoneScreening%20Script_4.1.2014.pdf

Appendix C

Demographics of Study Sample

What is your age?	***N (%)***	**How long have you been a Registered Nurse (RN)?**	***N (%)***
≤ 20	0 (0%)	< 1	0 (0%)
21-30	1 (14%)	1-5	2 (29%)
31-40	1 (14%)	6-10	4 (57%)
41-50	3 (43%)	11-15	0 (0%)
51-60	2 (29%)	16-20	0 (0%)
≥ 61	0 (0%)	> 20	1 (14%)

What gender do you identify as?	***N (%)***	**How many hours do you work a shift?**	***N (%)***
Female	6 (86%)	8 hours	7 (100%)
Male	1 (14%)	12 hours	0 (0%)
Other	0 (0%)	Other (specify)	0 (0%)

What is your current employment status?	***N (%)***	**How long have you been a charge nurse working at an inpatient psychiatric unit?**	***N (%)***
Full-time	5 (71%)	< 1	0 (0%)
Part-time	2 (29%)	1-5	5 (71%)
Per-Diem	0 (0%)	6-10	2 (29%)
On-Call	0 (0%)	11-15	0 (0%)
Other (specify)	0 (0%)	16-20	0 (0%)
		> 20	0 (0%)

How long have you been working in inpatient psychiatry?	***N (%)***	**On average, how often do you assume the role of a charge nurse per week?**	***N (%)***
< 1	0 (0%)	Some of the time (25%)	5 (71%)
1-5	3 (43%)	Half of the time (50%)	1 (14%)
6-10	2 (29%)	Most of the time (75%)	0 (0%)
11-15	1 (14%)	All of the time (100%)	1 (14%)
16-20	1 (14%)		
> 20	0 (0%)		

How long have you been a charge nurse of the inpatient psychiatric unit where you are currently working?	***N (%)***	**What type of unit are you usually in charge of?**	***N (%)***
< 1	0 (0%)	Adult, intensive care	2 (29%)
1-5	5 (71%)	Adult, step-down	1 (14%)
6-10	2 (29%)	Adolescents	1 (14%)
11-15	0 (0%)	Adult mixed (intensive care, step-down)	3 (43%)
16-20	0 (0%)		
> 20	0 (0%)		

How many other nurses (e.g., RNs, LVNs) and nursing assistants (e.g., mental health workers, mental health technicians, certified nursing assistants) are you in charge of on a typical shift?	***N (%)***
< 3	0 (0%)
3-5	3 (43%)
> 5	4 (57%)

Appendix D

Induction of Ordered Categories

First Order Categories	Second Order Categories	Third Order Categories	Induced Themes
(Pink) These are the difficult things that charge nurses deal with.	Personal/moral struggles – participants' own inner struggle of their external world Threats to safety or teamwork – interventions or differences in perspectives/opinions of patient care that create conflict between staff that also threatens safety/team	Participants run into conflicts with their staff or within themselves, in which they are compare and construct ways in which to cope with it in order to effectively manage the unit.	Effectively responding to interpersonal and intrapersonal conflict
(Green) These are examples of when charge nurses take two things that have something in common which they then compare.	Reality v. Ideal - you come in thinking it's one way, but it ends up not meeting expectations or changes your view; or when they have to decide between two different choices Structure of care – comparing the culture between shifts or staff or other departments/administration, interventions used in psych versus other units		
(Purple) These are situations where the charge nurse looks for ways to cope with their work.	Reframing your mindset - changing your perspective to deal with work Confidence or good understanding of their personal stance on work ethics		

First Order Categories	Second Order Categories	Third Order Categories	Induced Themes
(Yellow) These are responsibilities and tasks that charge nurses have to do at work. This includes both their general professional responsibilities, as well as their specific responsibilities that come with caring for patients in in-patient psychiatric units.	Staff/Unit management – how participants manage the unit (e.g., patient assignments, delegations) Communication – communicating information or educational material to patients or staff Patient care – how participants deal with de-escalation (verbal and intrusive measures) Secretarial tasks – not direct patient care activities that participants do (e.g., auditing, charting, orders, giving meds)	Participants shared examples of their role in working with staff as a leader and direct care provider in escalating or escalated situations with patients that threaten the safety of the unit.	Social-cognitive preparedness for the ever-present threat of crisis
(Blue) These are examples and descriptions of how charge nurses work with people.	Dynamics between staff of their professional or work-related interactions Connecting with staff/patients – having a deeper understanding of the shared goal that guides how they work with them		
(Orange) These are examples of the type of people and situations that force charge nurses to make decisions based solely on safety, instead of other considerations. Most of the time these are either emergency situations or situations that could quickly escalate into emergencies without immediate action.	Using or considering staff's abilities to match the patient's behaviors Identifying and intervening in a situation between staff and patient that was not going well, did not appear it will go well or description of general escalating sequence of events or considering situations that could escalate		

First Order Categories	Second Order Categories	Third Order Categories	Induced Themes
(Grey) These are situations where the charge nurse looks at past how people are socially labelled — for instance their diagnosis or their credentials — and speaks or understands them on a level human-to-human OR has a "humanized" feeling in the moment (e.g., fear) that is not usually spoken.	Empathizing with patients or staff and their situations/circumstances	N/A	N/A

Appendix E

Thematic Analysis of Theme 2: Effectively responding to interpersonal and intrapersonal conflict

Meaning Unit	Primary Investigator Interpretation or Summarization	First Order Categories	Second Order Categories	Third Order Categories	Induced Theme
14.20-14.23 "I feel a responsibility towards my coworkers and making sure that they are not, that they're viewed as important. I do think all of my coworkers are really important to what my job is." (P7)	Disagreement with peer about the consideration of other staffs' feelings. Feelings of staff: peer does not "care" about it but P7 disagrees and feel it's very important, especially to their job. Considering the feelings of staff is important to the effectiveness of the team.	Green – CNs take two things that have something in common and look at the difference (e.g., if this, then that…; this v. that; reality v. ideal)	**Comparison** Compares peers' feelings of staff to own personal view	**Impact** Discussed the importance of considering peers' feelings/emotions for teamwork and safety **Response** Talks about how she could've approached it differently	Effectively responding to interpersonal and intrapersonal conflicts
24.18-19 "I'm no longer just a person that's going to administer the medication; I'm the person that's responsible for the unit right now" (P6)	Comparing previous role as a licensed vocational nurse/medication nurse to now a registered nurse taking on the charge nurse position		**Comparison** of interventions	**Response** Self-realization /reality of the impact and importance of her role as the charge nurse	

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14.13-14.20 "…one of the nurse said, "I don't care about the feelings of the staff. I care about advocating for what's best for the patient"…the next day, and I was, like, man, that really hurt my feelings and I felt really angry and I had a hard time sleeping and I can't believe you feel that way. And the nurse repeated it. And I don't feel that way." (P7)	Disagreement with another charge nurse about the consideration of other staffs' feelings.	Pink – these are the hard (difficult) things CNs deal with (e.g., they work with things that they don't know fully about, have no control over, or can't see, hear, smell, feel, or taste) Inner struggles – turn between what you believe in and what others believe in	**Challenge** Staff creating division within the team	**Conflict with staff** Disagreement with peers' perspective caused personal angst	Effectively responding to interpersonal and intrapersonal conflicts
24.20-23 "It's a higher level of responsibility—afraid that you might be something wrong, that it could end up getting somebody hurt, that a patient could end up getting hurt because you didn't make the right call at the right time. Those are the type of fears that I had." (P6)	Participants recalls own initial fears coming into the charge nurse role from a different nursing position within the same field, i.e., charge nurse responsibilities, including questioning her ability to act to bring about safety and order.		**Challenges** Threats to safety or teamwork Unpredictability or uncertainty about consequences or outcomes	**Conflict with self** Fear, anxiety Feeling unprepared with new role even though working in field for years	

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14.23-15.2 “And I think for me not to pay attention to how they're feeling about things is unrealistic in managing. I think as a team, we need to be effective as a team, and having an effective team is so important to safety on our unit. And I think part of having an effective team is being aware of the emotional experiences of my coworkers. (P7)	How this participant’s perspective on considering the feelings of staff has helped her cope with being a leader of a team.	Purple - These are situations where the charge nurse looks for ways to cope with their work.	**Coping** Understanding their personal stance	**Response** to their personal view of managing a team as a charge nurse	Effectively responding to interpersonal and intrapersonal conflicts
25.2-25.6 “…just knowing that—do I know everything that I need to know to do this? and feeling comfortable in that, I guess, knowledge. I think it’s part of human nature when were put into new roles. Change can be anxiety-creating but once you walk through it, it can be a healthy thing.” (P6)	Participant coping with how to balance the fact that they may not knowing everything as a charge nurse, by embracing opportunities that can help fill that gap.		**Coping** Framing your mindset to deal with work	**Response** to the uncertainty or anxiety	