Ward Culture and Atmosphere

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1 Introduction

In mental health inpatient settings, the significance of ward climate as a crucial factor in the efficacy of inpatient care has been acknowledged for decades. Indeed as early as the 1950s, the World Health Organization (1953, p. 17) stated that 'the single most important factor in the efficacy of treatment given in a mental hospital appears to the committee to be an intangible element which can only be described as its atmosphere'. This chapter explores the multifaceted nature of ward culture and atmosphere, where these elements actively shape the therapeutic journey.

The functions of a ward, as summarised by Gunderson (1978)—containment, support, structure, involvement and validation—play a critical role in understanding the ward atmosphere and its impact on patient care. These functions highlight the dynamic nature of the ward environment, responsive to each patient's needs (Norton, 2004). Additionally, the work of Rudolf Moos since the 1960s has been instrumental in this field. Moos' conceptualisation of psychiatric hospital environments as having 'unique personalities' (Insel & Moos, 1974) comprises three dimensions: relationship, personal development and system maintenance and change. His research

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underscores the influence of an individual's perception of their environment on their behaviour, challenging the notion of personality as a predictor of behaviour irrespective of environmental context (Insel & Moos, 1974; Moos, 1973).

This chapter examines organisational culture within healthcare settings, particularly psychiatric wards, and its impact on patient outcomes and staff well-being. Staff attitudes and training significantly affect the ward's climate—a concept distinct yet related to culture. This climate, more temporal and malleable than culture, reflects current psychological conditions within the ward, playing a crucial role in patient and staff experiences. Also discussed is the role of the ward's physical environment in patient care. Research indicates that design elements like ward layout, safety measures and access to outdoor spaces significantly influence the use of seclusion and other coercive measures. The physical space is not just a setting but an active component in the therapeutic process. Central to the dynamics of a psychiatric ward are the rules that govern patient and staff behaviour. The manner in which rules are constructed, understood and enforced can either facilitate a therapeutic environment or contribute to a culture of control and coercion.

This chapter aims to provide a comprehensive understanding of the intricate aspects of ward culture and atmosphere. By examining the interdependencies between organisational culture, staff attitudes and training, the physical environment, and the rules and power dynamics, we seek to offer insights into creating more effective, compassionate and therapeutic psychiatric ward environments. The goal is to enhance both patient care and staff well-sbeing, fostering a culture of understanding, respect and collaboration within these critical healthcare settings.

2 Organisational Culture

Harrison (1972) defined organisational culture in terms of the beliefs and values of the organisation, which act as prescriptions for the way in which organisational members should work. Similarly, Smircich (1983, p. 346) stated that 'culture serves as a sense-making device that can guide and shape behavior'. The study of organisational culture is, therefore, about understanding people's perceptions of the organisations in which they work, and how these perceptions influence their attitudes and behaviour towards, and within, their work environment.

The general concept of culture has been around for many years with intellectual influences from both anthropology and sociology (Ouchi & Wilkins, 1985). However, the study and application of culture within an organisational context predominantly date from the 1970s and, in a reflection of its utility as a tool with which to gain insight into organisations, remain a large and growing area of organisational research. An influential theorist, Schein (2004), believed that culture existed across three main levels: artefacts, e.g. organisational rules, procedures and observable behaviours of employees; espoused values (which serve to determine employee beliefs about how things ought to be and what is important in the organisation); and basic assumptions (unconscious assumptions about appropriate behaviour and reactions in any given situation). Schein (2004, p. 17) defined culture as:

> A pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.

A similar concept to culture, primarily based on social and organisational contexts, is evident in 'climate' literature and research. In brief, culture is typically viewed as a deeper, more stable phenomenon than climate, which is temporal and less resistant to change. The study of organisational climate preceded that of organisational culture; climate has been conceptualised as a 'snapshot' of organisational culture (Mearns et al., 1998). Although there is some disagreement between researchers as to the definitions and appropriate measurement methods of culture and climate, indeed the terms are often used interchangeably, e.g. Glisson and James (2002), Rousseau's (1988) description of climate demonstrates the close relationship the concepts of climate and culture have in practice. She, along with others, considered climate as consisting of shared perceptions and beliefs. Having acknowledged the confusion that often exists between the two terms, the term culture is used throughout this section in an effort to ease comprehension for the reader.

It is widely accepted that organisations do not operate in one overall culture, rather they are composed of subcultures. Martin et al. (1985) detailed how it is more realistic to study organisational culture as an umbrella under which multiple subcultures exist, for example, corporate, departmental, divisional, geographical location, issue-related and professional (Jansen, 1994). The attention to culture at the ward level, as opposed to the broader organisational, e.g. hospital, level is therefore appropriate.

Culture is widely promoted as a tool for gaining insight into the workings of an organisation. Researchers have discussed culture as the key to understanding what makes some organisations more successful than others (Martin, 1992; Peters & Waterman, 1982). Others have looked at the impact that culture has on the well-being and performance of organisations (Denison, 1996; Wilkins, 1983). Specific elements of culture have also been examined, for example a positive safety culture is recognised as important in terms of reducing the risk of accident or error occurrence. Enquiries following safety incidents repeatedly identify cultural factors which significantly contributed to the chain of events preceding an incident, for example the Piper Alpha oil rig fire (Cullen, 1990), the Ladbroke Grove rail crash (Cullen, 2001) and the Deepwater Horizon explosion (Reader & O'Connor, 2014). While there is little agreement as to a definition of safety culture, commonly cited dimensions are leadership commitment to safety; open, trusting communication; organisational learning; a non-punitive approach to adverse event reporting; teamwork; and a shared belief in the importance of safety (Halligan & Zecevic, 2011). Much of this is captured in the concept of a 'just culture', which is gaining traction in healthcare and is a framework for addressing patient safety incidents and near-misses that moves away from blaming individuals to looking at systems (Paradiso & Sweeney, 2019). Similar non-blaming error reporting systems have been utilised in other industries, such as aviation, since the 1970s to improve safety and reliability (Gerstle, 2018) with blame

cultures believed to impede reporting and restrict learning from incidents (Swuste et al., 2020). A just culture is underpinned by openness with the intention to repair harm and to learn from incidents rather than to assign individual blame. A just culture has been attributed to significantly reducing air traffic incidents since the 1970s (Gerstle, 2018) and is beginning to deliver improvements in healthcare. In an examination of initiatives to foster a just culture in five healthcare organisations in the Netherlands, healthcare professionals highlighted the importance of open communication in incident analysis yet noted potential tension between openness and accountability (van Baarle et al., 2022). However, a study assessing the implementation of a just culture in a UK mental health trust observed positive outcomes, including reduced staff suspensions, dismissals and illness-related absences, alongside increased adverse event reporting (Kaur et al., 2019). Moreover, the total economic benefit of the introduction of a just culture was estimated to be about £2.5 million, which was approximately 1% of total costs and 2% of labour costs.

The role that organisational culture plays in violence is being increasingly recognised. Historically, patient violence was viewed as an individual issue, with most research, globally, focused on individual demographic factors related to violence such as age, gender and marital status (Bowers et al., 2011). Where staff were seen as causative they would be viewed as a 'bad apple', and whilst this can be the case, of more concern is the 'bad barrel', i.e. organisations that create oppressive and violent workplace environments (Bowen et al., 2011). Behaviours do not occur in isolation but rather within social and organisational contexts, and so improving the organisational culture, particularly where the culture has become toxic, can lead to a reduction of violence perpetrated by all the individuals within that culture. Toxic cultures have been demonstrated in numerous exposés of patient abuse in mental health settings in the UK, as seen recently on the BBC's *Panorama* (BBC, 2022). The relevance of culture within a ward environment and its influence on employee and patient attitudes and behaviour in relation to violent incidents is therefore clearly indicated.

Several researchers have looked at culture in a healthcare context; Braithwaite et al. (2017) identified 62 articles that explored the association between organisational and workplace cultures and patient outcomes, and they found that positive cultures were consistently associated with improved patient outcomes. In relation to violence and the way it is managed by staff, there is clear evidence that management practices are culturally local. There are national differences—data suggests that the Netherlands has higher rates of seclusion and restraint than three other European countries (Ireland, Germany and Wales) (Lepping et al., 2016)—and also regional differences—rates of restraint vary significantly across the UK (Care Quality Commission, 2020).

3 Ward Culture

Staff–patient interaction and the rules of the ward are of particular importance in the healthcare setting, and the ward culture is significantly shaped by the organisation of and the philosophy and nursing style adopted. According to Cortis (2003, p. 55), it is 'within this reality, or world view, an individual's purpose in life is defined, and

appropriate, sanctioned behavior within the social group is prescribed'. Kagawa-Singer and Chung (1994) argue that culture serves an integrative function, with beliefs and values providing an individual's sense of identity, and is also functional, in that the rules for behaviour allow a group to survive.

This is important in a potentially dangerous environment. Bowers (2002) endeavoured to establish what underpins a good ward culture, suggesting six underlying mechanisms: (1) a psychiatric philosophy, (2) a belief in the importance of psychosocial factors, (3) moral commitments and choices such as bravery, honesty and equality, (4) cognitive-emotional self- management, (5) technical mastery using interpersonal skills such as solving conflicts, teamwork skills to share the burden of care and maintain consistency in relation to rules and (6) organisational support.

Anna Björkdahl, one of this chapter's authors, argues that 'the only way to achieve a long-standing reduction in violence and aggression on acute [mental health] wards is to make fundamental changes to their culture' (cited in Parish, 2013). Promoting a recovery-based approach has been used successfully to overcome a risk-averse ward culture by supporting patient autonomy and independence to reduce incidents of deliberate self-harm, attempted suicide, absconding, and verbal and physical aggression (Henderson, 2013). Similarly, implementation of Safewards—the programme of interventions designed to promote a collaborative approach to creating safer and calmer mental health wards—has been shown to create a positive ward culture; two interventions, 'Know Each Other' and 'Clear Mutual Expectations' specifically facilitate culture change by increasing the sense of community (Fletcher et al., 2019).

4 Ward Atmosphere: Definitions and Measurement

Definitions of what constitutes ward atmosphere are difficult to find. This is hardly surprising given the complexity of factors involved. A lack of distinction between a plethora of terms such as 'ward and social atmosphere' (Jansson & Eklund, 2002), social ecology (Moos, 1974), social climate (Dickens et al., 2022), ward culture, ward milieu, ward environment and ward climate further complicates the issue. Edvardsson (2005, p. 8) uses the term 'atmosphere' to 'include the understanding and description of a tone or mood in care settings or…of what is contained 'within the walls' of that setting'. He sees the concepts of atmosphere and climate as interchangeable metaphors describing the psychological conditions of a social region. Schalast and Redies (2005), in a similar fashion, suggest that 'the interaction of aspects of the material, social and emotional conditions of a ward, which may—over time—influence the mood, behavior and self concept of the persons involved' are indicative of a 'ward atmosphere'.

The term 'ward atmosphere' in particular seems to be most commonly adopted in studies that focus on psychiatric settings. Moos (1974) may have been influential in this trend, devising what soon became known as the Ward Atmosphere Scale (WAS). This was developed in the 1960s in an attempt to describe and measure the therapeutic atmosphere in psychiatric and drug treatment settings.

The WAS consists of a 100-item questionnaire that measures views about the actual real ward, preferences about the ideal ward and individual expectations about the ward in general. It comprises three dimensions that highlight relationships, personal growth and system maintenance, each of which is reflected in ten subscales.

The WAS is still widely used to measure ward atmosphere in inpatient settings (Banks & Priebe, 2020), despite criticisms that it is dated, lacking content validity, its extensive size and limited psychometric properties. Partly to address these criticisms, Schalast et al. (2008) developed the Essen Climate Evaluation Schema (EssenCES), a 15-item scale measuring three dimensions of the social climate: therapeutic hold, patients' cohesion and mutual support and experienced safety. A review of scales to assess the social climate of prisons and forensic units found that the EssenCES was the second most used scale after the WAS (Tonkin, 2015). While the WAS and the EssenCES aim to assess the ward atmosphere as a whole, other scales have been developed to address specific aspects of the ward atmosphere, for example, the violence prevention climate, which can be described as the primary and secondary actions of staff and patients on a ward that prevent violence, as measured by the E13 (Björkdahl et al., 2013) and the VPC-14 (Hallett et al., 2018). All these measures, and more, have been used in studies assessing the impact of interventions to improve the social climate of acute mental health wards but most seem to lack robustness and sensitivity to change over time (Dickens et al., 2022). Dickens et al. (2022) in their review of just this identified that the interventions most likely to facilitate change in the social climate were Safewards and a ward-based psychological intervention described by Berry et al. (2016).

Ward atmosphere is a complex phenomenon because it describes the way a ward feels, which becomes difficult to define in concrete terms. A welcoming atmosphere may be created by (Weltens et al., 2021):

- Frequent strengths-based contact between patients and staff
- A multidisciplinary staff team
- Minimal use of coercive measures
- One-to-one nursing for agitated patients

While it may be difficult to explain the elements of ward atmosphere, it has been suggested that one gets a sense of the atmosphere as soon as one enters a ward; in the words of one mother, 'I can tell what kind of care my daughter is going to get within 15 steps of walking on to every new ward' (NHS England, 2017, p. 5). To this end, assessment of the ward atmosphere should be integral to approaches aimed at improving care. One method to do just this is the Fifteen Steps Challenge, which is a suite of toolkits that are used to explore healthcare settings through the eyes of patients and their carers (NHS England, 2017). This involves coordinating a 'walkaround team' who briefly visits wards to explore the quality of care under the headings of welcoming, safe, caring and involved, and well organised and calm. These are assessed by a series of prompts and questions.

The Fifteen Steps Challenge (https://www.england.nhs.uk/wp-content/uploads/2017/11/15-steps-mental-health.pdf)

Welcoming

- How does this ward make me feel?
- What interactions are taking place between staff and service users?
- Is there visible information that is useful and re-assuring? What is it?

Things to look out for

- Staff introducing themselves.
- Service users able to approach staff
- Staff photo boards with names.
- Body language of staff

Safe

- Can I identify staff? How are they identifiable?
- What tells me that staff take safety seriously?
- What did I experience that made me feel safe?

Things to look out for

- Information boards with transparent safety information e.g. safety crosses, graphs and charts.
- No clutter or overflowing bins.
- Staff in communal areas.
- Equipment and environment well maintained.

Caring and involving

- What can I understand about the service user experience on this ward?
- Is there evidence that service users and carers are involved in their own care?
- How do staff interact with service users?

Things to look out for

- Staff and service users positively interacting.
- Meaningful activities taking place.
- Service users speaking positively about staff and the care being received.
- Staff acknowledging service users and visitors with warmth and kindness.

Well organised and calm

- Does the ward feel calm even though it may be busy?
- Are resources/equipment stored in designated places?
- Does it feel like a therapeutic environment?

Things to look out for

- Staff not looking like they are under pressure.
- Organised and tidy communal areas.
- Service users and visitors looking relaxed.

5 The Relationship Between Ward Culture, Restrictive Interventions and Violence

Ward culture and restrictive interventions are intimately linked. Secker et al. (2004) suggest that the organisation of care can be hugely influential in levels of aggression and violence within the ward environment; this then forms the basis of a well-defined ward atmosphere. The ward culture, which includes the attitudes and beliefs of the staff and patients, can significantly impact the use of restrictive interventions such as seclusion and restraint. Staff attitudes towards coercive measures have seen a paradigm shift from a therapeutic paradigm to a safety paradigm (Doedens et al., 2020). The therapeutic paradigm viewed coercive measures as 'harsh, but helpful', extolling the calming nature of seclusion as an example. It is important to note that this view was not shared by patients. There are numerous qualitative accounts of patients' negative experiences with coercive measures at the time when the therapeutic paradigm was at its zenith. Restraint could leave people feeling afraid, powerless and helpless (Sequeira & Halstead, 2002; Smith, 1995; Wynn, 2004) while seclusion was described as punitive and could also leave people feeling afraid and helpless (Holmes et al., 2004; Lendemeijer & Shortridge-Baggett, 1997). More recently, the therapeutic paradigm has increasingly been viewed by staff as anathema, with attitudes shifting to the safety paradigm, where staff members view coercive measures as a last resort (Doedens et al., 2020). This can create feelings of conflict in staff who view coercive measures as a necessary evil.

A positive ward culture that prioritises collaboration, communication and person-centred care can help reduce the use of restrictive interventions (Department of Health, 2014). Staff members who work in such a culture recognise the importance of primary prevention interventions, i.e. interventions that prevent known reasons behind conflicts, as part of their everyday work. They are trained in de-escalation techniques and are more likely to recognise and respond to patients' needs before they escalate to the point of requiring restraint or seclusion. Additionally, staff members who feel empowered and supported in their work are less likely to resort to restrictive interventions as a means of managing challenging behaviours.

Conversely, a negative ward culture that prioritises control and coercion can lead to an increase in the use of restrictive interventions. This can create a culture of 'us versus them', where patients and staff are in conflict, rather than working towards a shared vision (Butterworth et al., 2022). Staff members who feel disempowered or unsupported in their work are more likely to resort to restrictive interventions as a way of exerting control over patients. Moreover, these interventions can create a negative feedback loop by eroding trust between staff and patients and contributing to a hostile and coercive ward culture.

6 Interplay Between Ward Atmosphere and External Factors

In mental health inpatient settings, the atmosphere and culture of the ward are influenced by, and affect, various interconnected factors. This section explores the elements relevant to the environment where patients and healthcare professionals interact. The quality of care, and the safety and well-being of individuals receiving treatment are significantly affected by many factors (Care Quality Commission, 2023; Pelto-Piri et al., 2019). Elements such as staff attitudes and training, the physical ward layout and the governing policies all contribute to these aspects. While other chapters in the book provide in-depth information on training, the physical environment and organisational policies, this section specifically focuses on their impact on the ward's atmosphere and culture.

6.1 Staff Attitudes and Training

While various studies have examined staff attitudes and characteristics, and their association with ward atmosphere and culture (e.g. Tuvesson & Eklund, 2017), few, if any, have demonstrated the impact of staff attitudes on ward atmosphere. Despite the lack of causal research, there is some evidence of a relationship between staff attitudes and ward atmosphere. In a cross-sectional study with staff working in a medium secure unit in the UK, Berry and Robertson (2019) found that a positive ward atmosphere was associated with lower levels of burnout. Furthermore, staff perceptions of ward climate may be a predictor of perceived barriers to change (Laker et al., 2020), meaning that implementing service-level changes may be more successful in wards with a positively perceived climate. This supports an earlier realist review of achieving lasting change when undertaking recovery-oriented training, which found that a challenging organisational climate could be a barrier to change (Gee et al., 2017).

The evidence for staff training is similarly scarce, although the available evidence does suggest that training can positively affect perceptions of ward atmosphere. A 3-week training programme aimed at raising awareness of the therapeutic environment, for nursing staff in a regional forensic hospital in Norway, improved patients' perceptions of the ward atmosphere as well as patient satisfaction (Nesset

et al., 2009). Moreover, staff and patients on wards that received training based on the Bergen model (a violence prevention training programme based on the positive appreciation of patients, emotional regulation and effective structure) had significantly higher perceptions of ward atmosphere than wards without that training (Björkdahl et al., 2013). Staff mindfulness training has also demonstrated an improvement in perceptions of ward atmosphere (Eliassen et al., 2016).

6.2 Physical Environment

The physical environment of a ward can have a significant impact on patient violence in mental health settings. Inpatient aggression and conflict result from a complex interaction of the individual characteristics of patients, staff characteristics and contextual characteristics, such as the physical environment of the ward. A study exploring the effect of design features on the risk of being secluded found that certain physical design features of psychiatric wards, such as outdoor spaces, special safety measures and the number of patients in a building, can affect the likelihood of using seclusion as an intervention (van der Schaaf et al., 2013). Specifically, a higher number of patients and special safety measures increased the risk, while more private space per patient, a higher level of comfort and better visibility within the ward were associated with a decreased risk. These findings highlight the importance of considering the physical ward environment in efforts to reduce the use of seclusion.

The Care Quality Commission (CQC), the independent regulator of health and social care in England, found that the physical environment and condition of mental health inpatient wards are 'not good enough', with many wards in need of urgent updates and repair (CQC, 2023). Issues that were observed included broken windows, holes in walls, dirty wards, and fixtures and fittings in need of repair. In many cases, the condition of wards has been made worse by the additional wear and tear created during lockdowns in the COVID-19 pandemic years. Many inpatient wards are in old and outdated buildings that lack the space and ventilation of newer buildings. This can lead to issues around privacy and dignity for patients, as well as compromise the safety of patients and staff. The relationship between a dignity-promoting culture and the preservation of dignity underscores the importance of both physical and interpersonal elements in healthcare environments. A study in a surgical ward found that a lack of privacy and staff behaviours that seem dismissive, too controlling or intrusive can threaten patient dignity (Baillie, 2009). Conversely, a physical space that respects privacy, coupled with a culture that values dignity and support from fellow patients, enhances it.

The field of 'health geography' explores how 'space, place, environment and landscape' can impact health professionals and patients (Philo, 1997). Philo (1997) offers a multifaceted examination of the geographical studies of asylums, emphasising the importance of understanding the complex interplay between societal perceptions, policy decisions and the physical environment in shaping mental health facilities. One study explored ward atmosphere and its relationship to the physical

environment, through the relocation of a ward to a purpose-built acute facility (Nicholls et al., 2015). While significant improvements were observed in some of the subscales of the WAS (order and organisation, and programme clarity), other indicators did not show improvement. This suggests that ward atmosphere encompasses more than just the physical environment; it also involves social interactions and occupation within that environment.

6.3 Organisational Policies and Procedures

Organisational frameworks and protocols are integral to ward atmosphere and can impact rates of incidents in mental health inpatient settings. Factors contributing to workplace violence include the unpredictable behaviours of emotionally stressed patients and relatives, alongside systemic issues such as stressful working conditions, staffing deficits, inadequate policies and training and operational inefficiencies like overcrowding and extended waiting periods (Jones et al., 2023). A supportive culture can reduce the impact of these factors. Evidence from other workplace settings, in this case social enterprises, suggests that a supportive management structure, clear role definitions and robust organisational processes are essential for sustaining staff morale (Joyce et al., 2022). Evidence from mental health settings underlines the critical role of leadership in fostering a supportive culture (Weltens et al., 2021). It suggests that while factors such as job strain, dissatisfaction with management and staff burnout can increase the risk of aggression, protective factors include effective teamwork and strong leadership.

An inflexible organisational culture can have unintentional consequences for patient dignity, as highlighted in a review of dignity as perceived by patients in hospital environments, including mental health settings (Ekpenyong et al., 2021). Patients highlighted situations where their choices were limited and their preferences overlooked, all in the effort to adhere to the organisational policies or frameworks; this was deemed to be ‘undignified care’.

One policy example that could be attributed to create an inflexible organisational culture is the ‘zero-tolerance’ approach to violence. While the aims of such an approach—to protect the workforce against violence from patients, their families and the public—are laudable, zero-tolerance approaches overlook the multifaceted nature of violence, attributing it merely to individual failings rather than organisational or systemic issues (Patterson et al., 2005). Zero-tolerance policies have been implemented across health services globally, yet the incidence of workplace violence remains high (Fan et al., 2022), suggesting that despite their popularity, they may be unsuccessful. Perhaps their popularity can be attributed to the fact that implementing such policies is a way for organisations to show support to their workforce. For example, despite being dropped by NHS Security Management in the early 2000s, the UK Government recently announced a ‘new, zero-tolerance approach … to protect he NHS workforce against deliberate violence’ (Department of Health and Social Care, 2018).

While zero-tolerance policies can create an inflexible ward culture, open door policies—maintaining open doors in hospital settings that would otherwise be locked (Gooding, 2021)—can have a positive effect on ward atmosphere. Staff and patients, according to an early review of locked doors in acute inpatient settings, identified that locked doors in psychiatric wards offer benefits, such as preventing the entry of illegal substances and reducing absconding and potential harm, and drawbacks, including negative psychological impacts on patients, increased feelings of confinement and additional workload for staff (van der Merwe et al., 2009). Furthermore, the practice of locking wards was linked to higher levels of patient aggression, decreased satisfaction with treatment and worsened symptomatology. Since that review there has been a proliferation of research examining the benefits of open door policies, much of which has found that such policies may actually decrease absconding and potential harm from, e.g. suicide, aggression and coercive interventions (Cibis et al., 2017; Huber et al., 2016; Lang et al., 2010; Schneeberger et al., 2017; Schreiber et al., 2022). Some authors postulate that the reduction in absconding behaviours may be due to improvements in the ward atmosphere (Lang et al., 2010). This supposition is supported by various studies that have examined the relationship between open doors and ward atmosphere, which indicate that open door policies in mental health hospitals are associated with improved ward atmosphere, including enhanced feelings of safety and patient coherence, without negatively impacting the therapeutic climate of existing open wards (Blaesi et al., 2015; Efkemann et al., 2019; Lo et al., 2018). Open settings are preferred over locked ones by involuntarily committed patients, showing higher ratings in safety and therapeutic hold, as measured by the EssenCES (Efkemann et al., 2019). The transition from locked to open wards may not compromise care quality or safety (Blaesi et al., 2015; Lo et al., 2018), suggesting that open door policies may foster a more positive therapeutic environment conducive to patient well-being.

Patient safety is intertwined with culture, policies and procedures, indeed, the World Health Organization (2021, p. vii) describes patient safety as:

> A framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make errors less likely and reduce the impact of harm when it does occur.

Many of the policies and procedures of healthcare organisations in the UK are overseen by the CQC. To improve patient safety, the CQC (2024) promotes a learning culture, expecting that providers, commissioners and leaders adhere to the following statement:

> We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Furthermore, the NHS has created the just and learning culture charter, in a bid to embed the value of a person-centred workplace that is compassionate, safe and fair when care goes wrong (NHS Resolution, 2023). According to the charter, to

have a learning culture, organisations must address accountability, leadership, patient and staff well-being, compassion, inclusivity, respect, candour, learning, best practice and evaluation. Adhering to the charter will include developing policies and procedures that align with a learning culture. The efforts of the CQC and NHS illustrate the UK's commitment to enhance patient safety by fostering learning cultures. Globally, the trend towards improving patient safety through the cultivation of various supportive cultures is gaining momentum. For instance, in the USA, changing from a blame culture to a learning culture has been used to improve patient safety (Hewitt et al., 2017). Furthermore, a patient safety institute in Singapore has demonstrated that enhancing patient safety involves cultivating various cultures, including 'speak up', 'reporting', 'learning', 'patient-centric' and 'just' (Tan et al., 2019). These cultures collectively contribute to a more open, informed and equitable healthcare environment.

While some may view restrictive interventions as necessary and unavoidable, aligning them with patient safety events is contentious. According to the World Health Organization (2021), such interventions could be seen as 'avoidable harm' rather than unavoidable measures. Furthermore, the World Health Organization (2019) categorises restrictive interventions as indicative of service and system failures, or sometimes failures on the part of individual staff members, suggesting that each instance should be regarded as an adverse event. This perspective shifts the view of restrictive interventions from being necessary and unavoidable to potentially being considered as adverse events, highlighting a need for change in organisational culture. This change, according to the World Health Organization's stance, would necessitate revisions in organisational policies and procedures to prevent what is deemed 'avoidable harm', thus challenging the notion that such interventions are a standard and acceptable part of patient care.

7 Rules and Power

From a more social perspective, the use of ward rules can be instrumental in the development and maintenance of the positive, or negative, culture of a ward. Indeed, the way rules are created and applied can be instrumental in setting the 'tone' or 'mood' of the ward; tone being one of the key features of Edvardsson's (2005, p. 8) definition of ward atmosphere. Rules in mental health settings are designed to maintain safety and order. They can include guidelines for patient behaviour, protocols for staff response to certain situations and procedures for managing crises (National Institute for Health and Care Excellence, 2015). Ward rules are necessary for maintaining order and safety but enforcement of rules can exacerbate the power imbalance that is inherent between staff and patients.

In their early review of ward rules, Alexander and Bowers (2004) found ambiguity in the literature. Many studies supported the use of highly structured approaches to reduce aggressive behaviour. However, a similar number found that strict settings can actually provoke violence in patients. Alexander (2005), in her subsequent PhD, found that clarity and consistency of rules, and also flexibility, contributed to a calm

ward atmosphere. Patients have identified that staff taking a flexible approach to rules is an important aspect of staff de-escalation (Price et al., 2018). Since de-escalation is the key secondary prevention tactic that staff can use to prevent imminent violence, this suggests that taking a pragmatic approach to rules may reduce violence.

Bowers et al. (2011) conducted a comprehensive literature review of nearly 1000 studies on inpatient violence and aggression. They found that limit setting was a precursor to violence in about half of the studies that identified antecedents. This is not surprising given the literature reviewed by Doyle and Clark (2020), which examined how ward rules and limit setting impact challenging behaviour. They found that enforcing hospital ward rules with a therapeutic intent, such as involving patients in rulemaking and understanding their behaviour, leads to positive outcomes like increased patient responsibility and reduced aggression. However, when rules were applied non-therapeutically, such as when staff made moral judgments about patient behaviour, it could negatively impact patients and exacerbate challenging behaviour.

Doyle and Clark (2020) found that understanding the reasoning behind rules may be important in reducing the negative impact of rules and limit setting. When patients do not understand the rules, they experience negative emotions. For example, Alexander (2006) found that patients felt claustrophobic and resentful when the ward was locked without explanation. Similarly, Gros et al. (2017) found that patients felt frustrated and disrespected when rules did not make sense to them. In a qualitative study by Price et al. (2018) about effective de-escalators, most patient participants felt that numerous arbitrary rules impacted challenging behaviour. For instance, patients were required to turn off the television at set times and had restricted access to water coolers at night. Enforcement of these rules was perceived as petty and negatively affected patients' relationships with staff. As a result, when the need for de-escalation arose, patients were less receptive to it. However, rules that promote safety, such as no hitting, may be seen as sensible and valued by patients (Gros et al., 2017; Johnson & Delaney, 2006). A solution to this issue is provided within the Safewards suite of interventions. 'Mutual Expectations' involves clarifying the expectations that staff and patients have of each other, which allows the staff to be consistent and the patients to understand their obligations and those of staff (Safewards, 2024). By implementing the 'Mutual Expectations' intervention, patients can have a better understanding of the rules and expectations, which can reduce negative emotions and improve their relationship with the staff. This can lead to a more positive and therapeutic environment.

It is useful to explore patients' motivations for following rules (Doyle & Clark, 2020). Patients who understand and agree with the rationale behind rules, seeing their connection to treatment, are more likely to follow them (Gros et al., 2017). On the other hand, patients adhering to rules without true agreement may show signs of withdrawal or disengage from the therapeutic process (Alexander, 2006; Gros et al., 2017). Such behaviour is often overlooked by medical staff, potentially leading to unmet patient needs or an unacknowledged risk of institutionalisation. Furthermore, patients often adhere to rules to gain privileges, avoid penalties or secure other

advantages (Bos et al., 2012; Gros et al., 2017). Some staff suggest that this adherence might mask underlying feelings of anger or thoughts of aggression and absconding (Alexander, 2006).

Finally, a section on rules would not be complete without consideration of blanket restrictions. Blanket restrictions are measures uniformly applied to all patients, such as fixed activity times, locked doors and limited facility access. They are sometimes mistakenly seen as general rules, as highlighted in the study by Price et al. (2018), where participants described them as rules that could be arbitrary and trivial. However, unlike ward rules, which are fixed and less frequently assessed because they are less likely to infringe on personal liberties (e.g. banning weapons and illegal substances), blanket restrictions require regular evaluation and adjustment based on fluctuating risk levels (Hinchcliffe, 2020). These measures aim to find a balance between safeguarding safety and minimising infringements on liberty and dignity, ensuring they are justified and proportional to the evaluated risk. Yet, an excessive focus on safety can foster a culture averse to any risk, which, as identified in a review of restrictiveness in forensic psychiatric care, can inadvertently legitimise the implementation of blanket restrictions (Tomlin et al., 2018). In CQC inspection reports of three high-secure hospitals in England, inspectors and patients highlighted the application of excessive restrictions, often viewed as unnecessary or illegal (Rabab et al., 2020). Issues were notably found with blanket restrictions affecting privacy, as well as access to food and kitchen areas. A specific instance highlighted was the denial of garden access to patients due to a lack of supervisory staff.

8 Implications and Hopes for the Future

In this chapter, a range of literature has been explored, some of which directly relates to ward atmosphere and coercion, but much of which has been applied given the limited research available. Implications for policy, particularly in terms of standardising procedures are evident. With regard to organisational culture, Scott et al. (2003) suggest that there should be an increase in the use of theoretical culture knowledge in empirical work, in addition to longitudinal and cross-sectional studies. Ultimately, the immediate and primary function of social science research should be to direct the process of change in mental healthcare and examine indiscriminate phenomena such as the ward culture and atmosphere. The need to examine this at different levels and from different perspectives cannot, therefore, be underestimated, and larger-scale studies are warranted.

In concluding this chapter, it is useful to consider what the implications are for practice, research and education. Practices within mental health settings should evolve towards a patient-centred approach, echoing the early insights about the significance of ward atmosphere highlighted by the World Health Organization (1953). This approach involves developing staff capabilities in nurturing a therapeutic ward environment where patients are integral to their treatment process. It also suggests reevaluating the physical ward space to ensure it supports therapeutic goals and

respects the dignity and individuality of each patient. Research in this field would benefit from a deeper exploration into the complex relationship between ward culture and patient outcomes, including staff well-being. This exploration should seek to understand the long-term effects of ward atmosphere on patient recovery. It could be beneficial to study the subtleties of rule enforcement and its psychological impact on patients, potentially leading to significant improvements in care. The education of mental health professionals could include an in-depth understanding of ward culture. This involves training future healthcare professionals in skills to positively influence the ward atmosphere, creating an environment conducive to healing. Such education should also emphasise empathy and respect for the complexities of the psychiatric ward, preparing practitioners to contribute effectively in these settings.

The ideal ward atmosphere in a mental health hospital setting, drawing from the historical insights and discussions within this chapter, should be a harmonious blend of various critical elements. It would embody a space where containment is balanced with compassion, ensuring patients' physical well-being while preventing violence in a manner that respects their dignity. Support should be a cornerstone, with an environment that makes patients feel comfortable and secure and reduces stress and anxiety. A structured approach to organising the ward, in terms of time, place and person, is crucial for providing predictability and stability. Involvement is another key aspect, where patients are encouraged and supported to engage with their social environment, facilitating a sense of community and belonging. Lastly, validation is paramount, where processes affirm each patient's individuality, acknowledging and respecting their unique experiences and perspectives. Such an atmosphere, responsive to each patient's needs, would not only enhance the efficacy of treatment but also promote a sense of well-being and empowerment among patients and staff. This environment would be underpinned by a culture of empathy, understanding and continuous learning, ensuring that the ward remains a dynamic space that adapts to the evolving needs of all.

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