**Patients’ perceptions of safety whilst in the acute phase of hospitalisation following a spinal cord injury**

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**THESIS PORTFOLIO: CANDIDATE DECLARATION**

|  |  |
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|  |
| --- |
| **Declaration and signature of candidate** |
| I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.  I confirm that the decision to submit this thesis is my own.  I confirm that except where explicitly stated, the work has not been submitted for another academic award.  I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.  Signed:  Date: 27/4/23 |

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**Thesis Abstract**

This thesis focuses on synthesising what is known on patients’ perceptions of safety within physical healthcare settings, and presents new research on this within a spinal cord injury setting.

The first paper is a literature review of patients’ perceptions of safety within physical health hospital settings. The aim of this literature review was to understand the main factors contributing to patients feeling psychologically safe within the physical health hospital environment. Searches were conducted during May and June 2022 and 11 studies were selected for the review. These were appraised using the CASP Qualitative Checklist Tool, and findings were analysed using thematic synthesis methods (Thomas & Harden, 2008). The review contained three main themes: ‘Communication with Staff’ (subthemes of information sharing, staff knowledge/competence, staff presence, staff attitude), ‘Connection and the Effects of This’ (support from others, isolation), and ‘Control Over the Situation and Self’ (physical environment, other patients, dependence on others, autonomy).

The second paper is an empirical study of patients’ perceptions of safety in the acute phase of hospitalisation following a spinal cord injury (SCI). This qualitative study consisted of interview data from eight participants who had experienced hospitalisation following SCI, and used Reflexive Thematic Analysis for analysis. Four themes were noted as having an impact on feelings of safety. ‘Staff Attributes and Interactions’, ‘Perceptions of Self and Autonomy’, ‘Impact of Others in the Ward’ and ‘Availability of Resources’. Clinical implications from the research include training for staff on the psychological impact of SCI, management of staff pressures to lessen dehumanising care, and trauma-informed hospital design, such as choice over shared spaces.

The third paper is an executive summary on the empirical research in Paper 2, aimed at the general population for wider dissemination of the research, including those with experience of hospitalisation following a SCI and healthcare professionals working within acute hospital settings.

*A note on the language used:*

Throughout this thesis portfolio, the word ‘patient’ is used and at times interchangeable with the words ‘participant’ and ‘individual’, dependent on the section of the report. The choice to use the word ‘patient’ was to distinguish this research from other research in the field that focuses on healthcare professionals’ and/or family members’ perceptions. As the empirical research took place within a physical health setting, the word patient was used to denote someone who is currently receiving inpatient care from the hospital. The word was also used by the individuals who participated in the empirical research to describe themselves and others receiving care.

# **Paper 1: Literature Review**

# **Patients’ perceptions of what contributes to feeling psychologically safe within physical health hospital settings**

Word count: 7535

(Excluding title page, references, and appendices)

This literature review is intended for publication in the British Journal of Health Psychology. Author guidelines can be found in Appendix 1. Further modifications will be made prior to submitting to the journal.

## **Abstract**

**Purpose**

The aim of this literature review is to understand the main factors contributing to patients feeling psychologically safe within the physical health hospital environment. In this review, psychological safety encompasses various concepts such as being able to exercise autonomy, feeling safe from harm and being able to engage with the environment (Hunt et al., 2021; Mollon, 2014).

Previous reviews (Kenward et al., 2017) have thus far not focused solely on patients’ perceptions of their own safety within physical health hospitals alone, nor included work before 2004 and post 2015, which this review does.

**Methods**

Following a scoping exercise, searches were conducted during May and June 2022 over the following sources: EBSCO database (which included CINAHL, PsycInfo, PsycArticles, MEDLINE), Scopus, Ethos, Open Grey. Citation searching and a search on Google Scholar was also conducted.

Eleven studies were selected for the review. These were appraised using the CASP Qualitative Checklist Tool, and findings were analysed using thematic synthesis methods (Thomas & Harden, 2008).

**Results**

Three main themes with ten subthemes were constructed: ‘Communication with Staff’ (subthemes of information sharing, staff knowledge/competence, staff presence, staff attitude), ‘Connection and the Effects of This’ (support from others, isolation), and ‘Control Over the Situation and Self’ (physical environment, other patients, dependence on others, autonomy).

**Conclusions**

More research or further reviews are required on the perceptions of marginalised groups in regard to how they perceive patient safety within physical health hospitals.

**Keywords:**

Patient, safety, hospital, physical health setting

## **Introduction**

In-patient hospital care is something many people will experience at some point in their lives, and a key part of secondary services provided by the National Health Service (NHS) in the United Kingdom (UK). In England, between 2020-2021, there were 16.2 million ‘finished consultant episodes’ (NHS Digital, 2021); this number reflects episodes of in-patient care throughout the year, rather than individual patients seen, and provides an idea as to how many individuals may be interacting with a hospital environment within a given year. In-patient or overnight stays are often only necessitated when the individual is severely ill or needing intense treatment, and therefore this can be a difficult time for an individual. Understanding what factors would contribute to the patient feeling safe within their environment could improve quality of care provided, as well as future experiences of patients.

The concept of ‘psychological safety’ is one that is often defined within organisational psychology as “being able to show and employ one’s self without fear of negative consequences of self-image, status or career” (Kahn, 1990, p.708). Psychological safety for patients is not as clearly defined, but could be considered as being able to engage with the environment without fear of dismissal or recrimination, feeling empowered to make choices and a sense of being treated with dignity (Hunt et al., 2021). Another definition from Mollon (2014) is that safety is a “sense of security and freedom from harm” (p.1729), which is supported by Kim et al.’s (2015) concept analysis of patient safety, suggesting it to be the protection from harm within a strong, organised system. It could also be understood in the context of Maslow’s (1943) hierarchy of needs, with safety needs including health, resources, and physical security being the fundamental parts on which other human needs (such as the need for connection) can be built.

Within healthcare settings, research on psychological safety predominately focuses on the healthcare staff teams’ perceptions of their own safety within a team (George & Lowe, 2019; Nembhard & Edmonson, 2006; O’Donovan & McAuliffe, 2020) or healthcare staffs’ perceptions of their patients’ safety (Mohammadi et al., 2020; Wassenaar et al., 2015). Much research that accounts for patients’ perceptions of their safety has focused on physical safety elements (Schmidt, 2003; Wolosin et al., 2006), rather than psychological safety. In addition to this, there is research on psychological safety for patients within psychiatric care (Gilburt et al., 2008). Gilburt et al. (2008) highlighted the importance of good quality staff-patient relationships, encompassing elements such as cultural sensitivity and clear communication. These concepts of what contributes to perceptions of safety within mental health care settings may be generalisable to physical health care settings, as the elements are relationship-based and not dependent on the physical environment to be implemented.

A review into patients’ experiences of feeling unsafe within hospitals was conducted by Kenward et al. (2017). This work identified seven themes that impacted patients in physical and mental health hospital settings, including poor communication or rationale, not having their needs taken seriously by healthcare professionals, extended time in hospital and care being depersonalised. Kenward et al.’s (2017) review chose to only include studies post-2002, stating this as a ‘turning point’ in patient safety culture following an NHS publication. However, this would have only affected UK-based care research, therefore unnecessarily limits research from other countries prior to this date.

This current review seeks to expand on that piece of work through not limiting inclusion of earlier works, namely, including works before 2002. This review also sought inclusion of more recent studies (post 2015), as well as consideration from a psychology-focused point of view as opposed to a nursing perspective. Other reviews included research from mental health hospitals; this review focuses purely on physical health hospitals to ascertain factors that affect patient safety within these settings. At the time of writing, there was no known review of patients’ perceptions of safety within physical health hospitals only.

### ***Aims***

The aim of this literature review is to understand the main factors contributing to patients feeling psychologically safe within the physical health hospital environment, as perceived and/or experienced by patients within physical health care settings.

## **Method**

### ***Search strategy***

A scoping exercise was initially conducted during March and April 2022 to gauge the amount of material available on patient perception of safety in hospital, and to ascertain appropriate search terms. This included a process of searching for terms such as ‘patients’ perceptions of safety’ and ‘safety perceptions within hospital’.

The search term chosen and used was in Boolean phrase format, with the following phrase:

*patient\* AND (perception\* OR experience\*) AND psychological AND safety AND (physical AND health) AND hospital NOT psychiatric*

Variations of the chosen phrase were considered and inputted, some of which elicited too wide a scope of information and some, too few. This phrase was selected due to this garnering the most relevant articles.

Final searches were then conducted in May and June 2022 through the EBSCO database, which included CINAHL, PsycInfo, PsycArticles, MEDLINE. These databases were selected due to the relevance to nursing, medical and psychology focused journals, in the hope of gaining a wide spectrum of research from different disciplines. Separate searches with the same keywords were conducted through Scopus and OpenGrey. For Scopus, the search term differed slightly in using ‘AND NOT psychiatric’, due to the database being unable to compute the search without this adjustment. OpenGrey was searched to ascertain if there was any grey literature fitting the search terms. EThOS was also searched for unpublished theses, however no results were found using the search term.

### ***Exclusion and inclusion criteria***

The following terms were excluded due to not answering the review question: nurses’/healthcare workers’ perceptions, caregivers’ perceptions only, psychiatric settings, mental health settings, studies where no translation was available in English (if translation was available in English or through automatic translation option on the databases, these were included/considered), previous syntheses or reviews.

Inclusion criteria was as follows: patients’ perspectives/experiences on safety within physical health hospital setting, written in English or English translation available.

No limiters regarding date range were set, due to no known literature review being available on the topic at the time of searching. There was no set limiter on the type of research included, however it transpired that the research selected was all qualitative, perhaps due to the nature of the question asked, which focused on experiences and perceptions, and lends itself to a qualitative research design.

### ***Selection process***

As detailed in the PRISMA diagram (Figure 1) (Page et al., 2021), 311 records were screened following removal of duplicates and research where no English translation was readily available. Two-hundred and fifty-two records were excluded at this stage, due to not meeting the inclusion criteria when title and abstract was screened. Fifty-nine records were then sought for retrieval, and abstracts were screened, with 35 records being excluded at this stage due to not meeting the inclusion criteria. During this phase, three records were unable to be retrieved, despite being screened at abstract and seemingly fitting the review aims. The three papers were noted and searched for within different databases; one was able to be retrieved, and was included within the next phase (Gómez-Carretero, 2007). For the other two, no full texts were available (Conley et al., 2003; Meert et al., 2008). Therefore three papers with no full text available were counted within the 35 records excluded.

Twenty-four papers were read in full to ascertain if they met the review aims. Fifteen were excluded at this point for the following reasons: about healthcare staff perspectives (n = 1), focusing on hospital management (n = 2), not relating to patients’ safety within the hospital environment (n = 6), patient’s perceptions of nurses’ safety, not their own (n = 1), relating to physical safety (n = 4), related to mental health admissions (n = 1). This left nine studies taken forward to be included within the literature review.

A search using the search terms was also conducted on Google Scholar, and returned six studies to be screened. Citation searching elicited nine articles for consideration. Fifteen studies were sought for retrieval, with 10 being excluded at abstract level. From the five taken forward to be read in full, one had no full text available (Vaismoradi et al., 2011), two were excluded for being unrelated to patients’ perceptions of safety (n = 1), and one for being related to perceptions of physical safety only (n = 1). Two studies were included within the review. A total of 11 studies were reviewed, appraised and synthesised.

***Publication bias***

Publication bias must be considered when conducting a review of the literature. Within qualitative studies, publication bias may occur in reporting of the results and lack of transparency in these, which would not enable an independent researcher to review the data and draw similar conclusions from this (Smith & Noble, 2014).

To counterbalance some publication bias, grey literature was sought in a bid to consider literature that had not been openly published or had been presented at conferences (Petticrew et al., 2008).

**Figure 1**

*PRISMA Flow Diagram Detailing Search Terms and Sources (Page et al., 2021)*

**Identification of studies via databases and registers**

**Identification**

**Included**

Records identified from:

Databases (n = 433): Scopus (139), EBSCO (289) (Medline (146), PsychInfo (96), PsycArticles (2), CINAHL (45)), OpenGrey (5)

EthoS (n = 0)

Records removed *before screening*:

Duplicate records removed (n = 117)

Records marked as ineligible by automation tools (n = 6 – no available translation)

Records removed for other reasons (n =)

Records screened

(n = 311)

Records excluded

(n = 252)

Reports sought for retrieval

(n = 59)

Reports not retrieved

(n = 35)

3 unavailable for full retrieval

Reports assessed for eligibility

(n = 24)

Reports excluded (n = 15):

About healthcare staff perspectives (n = 1)

Focusing on hospital management (n = 2)

Not relating to patients’ safety within the hospital environment (n = 6)

Patient’s perceptions of nurses’ safety, not their own (n = 1)

Relating to physical safety (n = 4)

Related to mental health admissions (n = 1)

Records identified from:

Websites (Google Scholar: n = 6)

Citation searching (n = 9)

Reports assessed for eligibility

(n = 3)

Reports excluded:

Not related to patients’ perceptions of safety (n = 1)

Related to perceptions of physical safety only (n = 1)

Studies included in review

(n = 9)

Reports of included studies

(n = 2)

Total = (n = 11)

Reports sought for retrieval

(n = 15)

Reports not retrieved

(n = 12)

**Screening**

**Identification of studies via other methods**

***Appraisal process***

The Critical Appraisal Skills Programme (CASP, 2018) appraisal tool for qualitative research was selected to critically appraise and evaluate the quality of the research included for review. This tool provides a framework to critically appraise individual pieces of qualitative research and was selected as recommended by NICE guidelines (2014). The study characteristics table, including main findings and main critiques, is included (Table 1).

Critical Appraisal Skills Programme (CASP, 2018) checklist tools for qualitative studies are intended to be used to evaluate study quality and the creators do not recommend a scoring system for the tools. Studies included therefore were not assigned ‘scores’ to measure the quality of the information, however answers to each question from the CASP tool used for each study appraised were compiled in a table (Appendix 2). This enabled a consideration of where the studies shared similar characteristics.

### ***Thematic Synthesis***

As the review sought to understand patients’ experiences within physical healthcare settings, using a thematic synthesis approach was appropriate. This approach enables the data within the selected papers to be considered in regards to the review question, and novel themes to be considered across the research findings, to understand which factors are most pertinent to patients’ perceptions of safety.

To conduct the thematic synthesis of the findings, the following process occurred, as outlined in Thomas & Harden (2008): initial codes were developed from the texts of the papers from both prose and direct quotes, and inputted into a table. Themes were constructed from these initial codes when the texts were re-read. Themes were then reviewed, defined, and transposed the original data to a novel understanding of the texts. This resulted in the synthesis of data which is presented within the results section and these steps were all conducted by the author.

## **Results**

***Appraisal and quality of research included***

All studies included had clear aims of research (Q1), and qualitative methodology was appropriate for these studies due to exploratory nature of seeking participants’ experiences (Q2). All studies included were also deemed to be useful locally (Q10), due to meeting inclusion criteria for this review.

Five out of the eleven studies included were appraised as having appropriately considered the relationship between the researcher and the participants, however the remaining studies were appraised as not, or unable to tell. When appraising the studies, there appeared to be a lack of

**Table 1**

*Study Characteristics Table*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Study no.** | **Study and country** | **Type of setting/**  **medical issue** | **No. of pts, age of pts and demographics**  **(if known)** | **Method** | **Type of analysis** | **Main findings** | **Critiques** |
| 1 | Barkensjo et al. (2018)  Sweden | Perinatal, maternity | N = 13  18-36 years old  13 women – migrants from 10 different countries | Unstructured interviews Range: 14-75 mins length  Average: 36 min | Content analysis | -Being heard and acknowledged by healthcare providers increased trust and feelings of security  - Underlying anxiety regarding personal situation increased need for security and safety from healthcare professionals  - Flexibility in providing care and taking time to build relationships increases feelings of safety and trust | - 18 interviews, however 8 were during pregnancy, then 5 post-partum, and another 5 were just post-partum. Difficulties with retainment due to various factors  - Data reliability questions: different interpreters used (1 professional, 1 volunteer, 1 doula, 5 adult relatives), and not all audio transcribed, two had notes made instead  -Vulnerable group, may not have felt empowered to decline or to speak freely, for fear of recrimination? |
| 2 | Browall (2013)  Sweden | Oncology | N = 11  32-72 years (mean: 54)  7 women  4 men | Focus group interviews | Content analysis | - Importance of safety in the form of continuity of care provided and privacy  - Importance of physical environment including sensory experiences (smell, sounds, visual aspects)  - Being considered as a person, sharing experiences with others including loved ones, and good communication were important factors | -Focus group style interviews may have influenced participants’ responses to the general consensus of the group  - Participants had contributed to previous study and were asked about contributing to future studies – possible sampling bias? |
| 3 | Hassel, Anderson, Koinberg & Wennstrom (2016)  Sweden | Proctectomy patients following rectal cancer | N = 10  61-87 years (median: 71)  5 women  5 men | Not stated – appears to be semi-structured individual interviews  Range: 30-90 min | Content analysis | - Maintaining independence, feeling supported, feeling seen, continuity of care and positive attitude are key factors in feeling safe  - Factors contributing to not feeling safe included complications, feeling isolated and feeling restricted | -Recruitment was through therapists unconnected to the study reviewing records and selecting potential participants based on inclusion criteria, then researcher contacting them. Raises questions of ethics and confidentiality  -No mention of contradictory evidence |
| 4 | Heine, Koch & Goldie (2004)  Australia | Hip replacement patients | N = 5  43-79 years  2 women  3 men | In-depth unstructured interviews  Range: 30-75min | Grounded theory | -Three categories: feeling safe, family and friends, confidence  -Interactions with staff influenced how confident patients felt, as well as consistent and timely information  -Support affected feeling of safety, and experienced staff contributed to this | -Small sample size; no reason given for one declining, also sample size was justified through data saturation but seemingly not taken beyond saturation to check  -Ethical review, however no mention of ethical considerations |
| 5 | Hupcey (2000)  USA | ICU | N = 45  25-80 years  (mean: 59 years)  25 women  20 men | Unstructured interviews  Range: 15-60min | Grounded theory | *-*Feeling safe, including knowing what was happening, hoping, regaining control and trusting in the healthcare professionals.  -Family and friends, faith and staff also have an influence on feeling safe | - No critical consideration of researcher’s role in collecting data  -No justification for methods used, although appropriate  -States ‘diverse’ sample, however no demographics given beyond age and geography |
| 6 | Komatsu, Yagasaki, Yamauchi & Yamauchi (2016)  Japan | Chemotherapy for breast cancer patients | N = 17  37-66 years (mean: 49.4 yrs.)  17 women | Semi-structured qualitative interviews  Range: 30-50min | Grounded theory | -Loss of control, personal safety net (including maintaining routines and having a support network), re-evaluating life  -Creating own safety nets increased confidence and control  -‘Secure’ physical environment important for this | -Recruited through list of outpatients but no mention of how they were contacted  -Translated into English by professional translator  -Interviews conducted within the treatment hospital |
| 7 | Larkin, Begley & Devane (2012)  Ireland | Maternity services | N = 25  20-39 years  25 women -  Irish (20), Asian (3), White Northern American (1),  Eastern European (1) | Focus group interviews | Thematic analysis | -Information helped the women feel more in control  -Physical environment and loudness of others increased anxiety  -Isolation post-birth affected feelings of safety and increased anxiety for future births | -Little diversity within the sample  -No mention of ethical review |
| 8 | Lasiter (2011)  USA | ICU | 10  65-93 years  5 women  5 men  Older adults | Semi-structured interviews  Range: 30-60mins Average: 45 mins | Grounded theory | Perception of control in the situation, experienced and visible nurses/healthcares around  -Role of faith in feeling safe  -Knowledge of being monitored contributed to feeling safe | -Participants interviewed in two different places each – in intermediate care and then in own homes  -No ethnic diversity within the sample  -Interview guide ensures each question was asked to each participant, however unsure how this fits with grounded theory  -Two interviews due to fatigue effects however time and change of location may have affected responses (9 interviewed twice, 1 interviewed once)  -PhD thesis |
| 9 | Lyndon et al. (2018)  USA | Maternity services | 17  29-47 years  17 women – White (13), Asian (1), unknown (3) | Interviews – individual (3) and small group (14 – in groups of 2 or 3) | Thematic analysis | -Safety as a continuum, environmental/organisational factors, interpersonal interactions and human connection  -Factors affecting feelings of safety included: competence of healthcare providers, consistency of care, monitoring, privacy  -Feeling unsafe included inappropriate interactions with staff | - Recruitment unclear; stated recruited purposefully through a parent advisor, however not detailed how participants were approached, and leaflets posted online and physically. Unclear if this was a self-selecting sample or not.  -Differing places for interviews – medical centre or at home of parent advisor |
| 10 | New, Goodridge, Kappel, Groot & Dobson (2019)  Canada | Chronic kidney disease | 30  Unsure of exact ages of pts: 22pts over 50 years, 8pts under 50 years old.  14 women  16 men  Ethnicity – 16 non-indigenous Canadian, 14 indigenous Canadian | Interviews – open-ended interview guide used | Interpretive description analysis | -Main themes: ‘receiving care, expected to be taken care of, being cared for, reporting safety concerns’  -‘Care of’ pertains to physical needs being met, ‘cared for’ connotes psychological/interpersonal needs being met  -Other patients or people were perceived to impact feelings of safety, including having to share a room with others and possible new infections, and listening to others in pain | -Interviews at bedside may have impacted responses  -Purposive sampling through MDT rounds, but no mention of prior relationship/involvement in care between participant and researcher |
| 11 | Worster & Holmes (2009)  UK | Colorectal cancer patients | 20  50-82 years  10 women  10 men  All Caucasian | Semi-structured interviews  Average: 45min in length | Phenomenological | -Themes included needing information, gratitude, loss of dignity (including privacy), loss of control and mobility | -No acknowledgement of how many didn’t opt to take part or why  -Late stage diagnosis and surgery in the UK; findings may have been different if at an earlier stage |

consideration of researchers’ critical examination of their own role within the study, such as within Barkensjo et al. (2018), or a lack of acknowledgement of involvement or not in patient care (New et al., 2019). Being aware that researcher-participant relationships were unclear within some of the studies raised questions of reliability of the results, and of ethical considerations.

Five of the eleven studies also had unclear ethical issues. Although the majority had ethics reviews from local or national committees, there were some studies that did not mention this (Larkin et al., 2012) or noted that the study had adhered to Ethical Review Act, however no explicit ethical review for the study (Hassel et al., 2012).

It also feels important to note that although the CASP tools provide a framework for critical appraisal and encourages a balanced view of the literature available, they do not make the appraisal immune from reviewer bias. During all stages of the literature review, from selection to appraisal to analysis, the author aimed to be reflective and considerate of own biases in order to maintain research integrity.

There were three main themes from the data: ‘Communication with Staff’, ‘Connection and the Effects of This’, and ‘Control Over the Situation and Self’, that affected patients’ perceptions of safety within hospital. Subthemes are considered within each theme heading, and a table of themes and subthemes is provided (Table 4).

**Table 4**

*Table of Themes and Subthemes.*

|  |  |
| --- | --- |
| **Theme** | **Subtheme** |
| **Communication with staff** | Information sharing |
|  | Staff knowledge/competence |
|  | Staff presence |
|  | Staff attitude |
| **Connection and the effects of this** | Support from others: family, friends, other patients and staff |
|  | Isolation |
| **Control over the situation and self** | Physical environment: equipment/facilities/sensory aspects |
|  | Other patients |
|  | Dependence on others |
|  | Autonomy |

### ***Communication with staff***

Communication with staff appeared as a common experience through all papers, and encompassed the patients’ perspectives on the quality, quantity and sharing of the information between patients and staff within the physical health setting, both verbal and non-verbal. This theme included the subthemes of staff attitude, staff presence, information sharing and staff knowledge/competence.

**Staff attitude.** Patients reported being affected by staff attitudes towards the patients and

their work, both negatively and positively. The staff’s attitudes affected the patients’ moods and in turn, this appeared to influence the patients’ feelings of safety.

It bothers me when they are stressed and they are asking me questions, like shooting questions and I’m trying to think and, when they are stressed and they transmit that to me. Yeah, that’s one thing that I’m bothered by a lot. (Hupcey, 2000, p. 5.)

Similarly, within Lyndon (2018), staff attitudes towards patients, including talking over them and discussing their private lives without including the patient, left the patient feeling invalidated. New et al. (2019) noted patients’ perceptions of staff attitudes as being negative or uncaring to affect their perceptions of safety: “I don’t feel safe because what is, something is going on, they are not talking to me if nothing is going on but I would like to know either way and I’ve asked.” (p. 5).

**Staff presence.** Having a consistent staff team increased feelings of safety as opposed to

when patients had unknown staff teams looking after them. “I was still with the same nurses…If I was with a bunch of new nurses that I didn’t have a trusting relationship with, that would have definitely probably affected my feeling of safety.” (Lyndon et al., 2018, p. 5).

There were also observations that having a physical staff presence on the ward was a comfort to patients, such as seeing nurses from the bay (Lasiter, 2011). Within Heine et al. (2004), it was noted that the sense of someone being immediately available increased feelings of safety: “… like in hospital I feel safe because I know I just have to ring a buzzer and someone will be there.” (p. 5).

**Information sharing.** The subtheme of information sharing between staff and patients

within hospital occurred in every paper reviewed. Information such as letting the patient know what to expect for their procedures (Lasiter, 2011; Hassel, 2016), and presented in a variety of ways such as written, verbal and pictorial form (Browall et al., 2013; Lasiter, 2011), was beneficial to the patients’ perceptions of safety. Sharing information honestly and comprehensively appeared to increase feelings of safety: “I felt prepared for whatever outcome was going to happen. They’d really educated us and made us feel safe” (Lyndon et al., 2018, p. 6).

Failure to adapt information, such as through translation in the case of migrant women, resulted in “feelings of losing control of what was happening to them” (Barkensjo et al., 2018, p. 9).

Receiving inadequate information also increased the risk of a physical threat to safety and wellbeing.

There was no talk of pain after the operation, we didn’t have a clue that it would last this long… I hope that future patients will get some backup information about how tight the skin may get and that you can get all those problems. No one said a word about it! (Patient 2) (Hassel et al., 2016, p. 6).

There was also a sense of patients ‘find[ing] answers to lots of questions themselves’ (Browall et al., 2013) and having to be prepared to know their own rights in case they have to ‘argue’ with professionals (Barkensjo et al., 2018). Patients also relied on information being shared with family, friends or trusted nurses, as they found it difficult to make sense of the information (Worster & Holmes, 2009). Inconsistencies in information contributed to patients feeling unsafe (New et al., 2019).

**Staff knowledge/competence.** Patients’ perceptions of the competency of surrounding staff

affected their feelings of safety. New et al. (2019) stated that ‘some participants felt that they had to be vigilant and monitor for any breaches in practice’ in regards to infection control procedures, especially if the patients had experienced threats to their safety previously within hospital: “Well I definitely ask what kind of, what am I given” (New et al., 2019, p. 6).

Competencies also covered staff’s cultural competencies and knowledge. For example, within Barkensjo et al. (2018): “Insufficient knowledge displayed itself in a variety of ways, such as the reoccurrence of questioning the women’s right to healthcare services, and being unaware that this population encounters difficulties” (p. 6).

There was an expectation that staff knew what and why they were completing a task and that this would be shared with the patients, as this was ‘integral to bolstering their [the patients’] sense of security’ (Browall et al., 2013).

### ***Connection and the effects of this***

Connection and the effects of connection with others was a key experience in patients’ perceptions of safety. Positive connections with others and themselves contributed to feeling safe, whereas the lack of connection to others resulted in feelings of isolation and feeling less safe. This theme included subthemes of support from others (family, friends, other patients, staff and religion) and feelings of isolation.

**Support from others.** Creating a ‘personal safety net’ and having support from

others enabled patients to ‘hibernate’ and concentrate on getting well (Komatsu et al., 2016).

Family and friends were an important source of support throughout the studies reviewed. However, comments from family and friends could have positive or negative effects on perceptions of safety, by calming or causing worry to the patient (Lasiter, 2011).

Support from healthcare professionals was also important in patients’ safety. This was different from communication, in that the relationship with staff members felt more on a personal level. Examples of this were physical touch such a hug or touch of a hand (Browall et al., 2013; Lyndon et al., 2018), or being listened to, such as within Browall (2013): “The impact of positive feedback and being noticed and listened to by the staff was considered to be crucial for the feeling of being seen as a unique individual and not just a patient.” (p. 6).

Sources of support were also experienced in other ways, such as when depersonalised relationships resulted in patients feeling uncertain: “When providers did not develop relationships and engage with the participants in a more personal way for the birth, participants were left with feelings of uncertainty and disappointment.” (Lyndon et al., 2018, p. 6).

Additionally, a belief in religion was seen as a support by some (Hupcey, 2000; Lasiter, 2011), with the sense of safety stemming from trusting in something other than themselves.

**Isolation.** Effects of being ill left patients isolated physically and emotionally from others,

resulting in negative emotions such as depression (Komatsu et al., 2016). Isolation from support networks also impacted feelings of safety, such as when women were not able to have partners present during births (Barkensjo et al., 2018; Larkin et al., 2012). Isolation within the hospital included not feeling safe enough to share experiences, as noted in Barkensjo et al. (2018), due to women with migrant status feeling unable to speak to healthcare professionals for fear of recrimination.

Isolation was at times self-imposed, as patients did not wish to ‘entertain’ family or visitors (Lasiter, 2011).

### ***Control over the situation and self***

This theme contained how a perceived sense of control over the situation and/or self increased feelings of safety for patients. The theme of ‘Control over the situation and self’ included participants’ experiences of the physical environment (equipment/facilities/sensory aspects), other patients, dependence on others and lack of autonomy.

**Physical environment.** The physical environment was an aspect that contributed to feelings

of safety. Being able to see that clinicians were able to work and having medical equipment within site was helpful for patients, for example within Lyndon et al. (2018) “participants noted that “well-equipped” facilities, adequate space for clinicians to work, and proximity to emergency equipment or the operating room contributed to their feelings of safety” (p. 4).

Medical equipment could also however have a negative effect on perceptions of safety. Routine clinical noises from equipment lead some patients to feeling less safe in the environment due to being experienced as frightening and stressful (Lyndon et al., 2018).

Inability to control sensory aspects of the environment also contributed to feeling less safe, such as unpleasant smells (Hassel et al., 2016; Lyndon et al., 2018; Worster & Holmes, 2009). Noises and the hospital routines also disturbed patients’ sleep, negatively affecting wellbeing (Worster & Holmes, 2009). However, if the sensory aspects were pleasant, such as soft lighting, this increased feelings of safety (Lyndon et al., 2018).

**Other patients.** ‘Other patients’ came up within the literature as a factor impacting

patients’ perceptions of safety and one that was beyond the patients’ control. For example, whilst other patients could be a source of support (Barkensjo et al., 2018), this could also be a source of stress for some. Hearing others in pain lead to patients feeling unsafe themselves (Larkin et al., 2012), and having unknown visitors increased anxiety (Hupcey, 2000). Furthermore, seeing other patients acutely unwell increased patients’ awareness of their own conditions, adversely affecting mood (Browall et al., 2013).

**Dependence on others.** Dependence on others for basic care needs such as personal

hygiene contributed to patients’ feeling uneasy (Hassel et al., 2016; Worster & Holmes, 2009). This included dependence on medical intervention for basic needs, for example within Worster & Holmes (2009): “The lack of oral fluids and food in the immediate postoperative phase was particularly important resulting in both physical and psychological discomfort” (p. 5). The impact of being unable to care for themselves and loss of independence affected patients’ perceptions of safety. “Others had more intense feelings of a total loss of independence because they could not care for or make decisions for themselves” (Hupcey, 2000, p. 3).

**Autonomy.** Inpatient hospital stays result in having to adhere to the hospital routine, which was a source of negative feelings for patients, as noted within Browall et al. (2013): “Being forced to adhere to clinic routines - sleeping, eating, and living in close proximity to strangers when you are feeling vulnerable and exposed - was stated by several study participants to be both demanding and demeaning.” (p. 6).

Having a choice over whether to socialise or not was an important aspect in wellbeing, and could be seen as a positive, for example: “The availability of single rooms with en-suite toilets and showers was perceived by many as being very positive in terms of allowing them to choose to either be alone or socialize with others” (Browall et al., 2013, p. 6). The inability to socialise with family and friends however could attribute to negative feelings, and this was a crossover with the subtheme of ‘support from others’ within Theme 2. Hupcey (2000) noted that being unable to have visitors for more than 10 minutes at a time due to hospital routines negatively affected patients’ wellbeing and therefore psychological safety, and this inability was something that was beyond the patients’ control.

Having autonomy or control over certain aspects, such as considering interventions (Larkin et al., 2012), and ‘being informed about alternative options’ (Browall et al., 2013, p. 6) was seen as a positive aspect for patients and valued by them, increasing feelings of safety.

## **Discussion**

The concept of safety is complex and highly individualised. Within the studies analysed, a predetermined definition of safety was not provided for the participants; instead, open-ended interviews sought to elicit what the patient would define as safety. Rather than a single definition, safety appears to be more of a collection of factors; this review suggested information sharing, support from others, autonomy and staff presence to be amongst some of the factors affecting perceptions of safety. This is in-line with previous reviews on patient safety which suggest nursing care, having relatives present and availability and visibility of technology such as monitoring machines to be key factors in feelings of safety (Wassenaar et al., 2014; Wassenaar et al., 2015), as well as the review by Kenward et al. (2017), which highlighted the key themes of loss of control, staff presence and information and communication. However, this review also highlighted the importance of support from others, such as family and friends, on patients’ perceptions of safety. Given the recent COVID-19 pandemic and visitations from family and friends being limited for patients, this finding is further supported by Hugelius et al.’s (2021) integrative review of the effects of limited visitations within hospital, with loneliness and depression being psychological effects of this.

The three themes and ten subthemes highlighted some factors patients find affect their perceptions of safety when in inpatient hospital care. The main theme findings of ‘Communication With Staff’, ‘Connection And The Effects of This’ and ‘Control Over The Situation and Self’ serve as starting points for considerations for applications to clinical practice into what affects an individual’s perceptions of safety within physical health hospitals.

The theme findings within this review were also in-line with research from mental health healthcare, which suggests help, safety and power to be key themes implications in ensuring patients’ perceptions of safety (Stenhouse, 2013); for example, having a male nurse on shift was noted to increase feelings of being protected and feeling safe for patients within an in-patient psychiatric setting. This suggests that although these are different settings with different patient needs, there are common factors contributing to patient perceptions of safety.

‘Staff attitude’ towards patients and their work contributed to patient perception of safety. Although staff work in the hospital every day, it seems important for staff to be aware of the impact of their behaviours, body language and discussions may have on the patients’ wellbeing and sense of safety. This is particularly pertinent in a time of high workloads and burnout amongst healthcare professionals since the pandemic (Gualano et al., 2021), and serves as evidence for wider management systems to acknowledge the impact of stress on not only the workers themselves, but the patients they are caring for. Increasing support for staff may benefit staff wellbeing and therefore patient care, and this would require organisational as well as individual interventions (Morse et al., 2012; Litam & Balkin, 2021). Within busy healthcare systems, staff members must be supported to do their work effectively by strong organisational management. Smaller examples of increasing wellbeing could include reflective practice opportunities, as well as establishing a culture of taking breaks.

Staff presence and consistency was a key subtheme element within ‘Communication with Staff’. Patients expressed staff not knowing them or their circumstances, and feeling unsafe if they had unknown healthcare workers. Consistency of staff is not always possible within healthcare, therefore making effective and timely information sharing about patients’ specific care needs even more pertinent for patients to feel safe. Information sharing with key people such as family and friends, and in a variety of mediums, enhanced safety for patients with the knowledge that others could relay the information and ask questions on their behalf?. This is mirrored in other research such as preferences for information sharing with family and friends in older patients (Crotty et al., 2015). It must be considered, however, that this is not always standard practice due to various factors such as time constraints on the ward, and must always be patient-led, to ensure autonomy and privacy for the patient involved.

‘Connection and the Effects of This’ as a theme highlighted the importance of social support for the patients in hospital. This social support, from friends, family, other patients or trusted healthcare staff, gave patients encouragement and a sense of safety. Isolation, although not necessarily a negative concept, can cause patients to feel a lack of connection to others and feel unsafe, such as in the case of isolation for infection control purposes such as MRSA (Barratt et al., 2010). For some patients, the isolation can be welcomed and increase feelings of safety. Therefore, it must be considered that some aspects of patients’ perceptions of safety are dependent on the individual and any adjustments must be person-centred. Any adjustments must also adhere to what is possible within healthcare settings on a practical level.

When in hospital, whether expected or not, a patient’s perception of control in the situation affected their feelings of safety. The physical environment could promote feelings of safety or of unease in a patient. Being aware of the aspects that affect patients’ perceptions of safety, such as unpleasant smells (sensory environments), could be simple ways for hospitals to adapt to be more comfortable and safer for patients. The subtheme of ‘other patients’ highlighted vulnerability of patients sharing space with unknown others and their visitors, and the threats to privacy, dignity and personal safety that this may hold. Although private rooms and en-suites were contributing factors to feeling more in control of the environment and therefore safer, this must also be balanced with not isolating patients and also the practicalities of providing such spaces for each patient.

### ***Strengths and limitations of the review***

When considering a literature review, it is important to note that the literature found and included is in itself implicitly bias, due to publication bias. Studies with more positive findings are more likely to be published, and within qualitative studies, research can be susceptible to similar biases in that studies with minimal or less profound results are unlikely to be published than more positive ones (Petticrew et al., 2008). A lack of rigour within methodology therefore affecting replicability can be an issue within qualitative studies (Smith & Noble, 2014). An attempt to counteract the publication bias was made through searching through grey literature and Ethos, however for this review, there were no relevant pieces of research from these searches. It must also be considered that the thematic synthesis was conducted from the quotations provided within the papers reviewed, and therefore may be subject to some publication bias from the authors in regards to which quotes were chosen to support their themes. There is also a limitation within the review that the papers were only sought and selected by one researcher; more researchers conducting the review may have given more opportunity for reflection on findings.

It must also be considered that within this current review, there is little diversity amongst the studies, with all except one of the studies being conducted in Western countries with a majority white study participant population. This may affect generalisability to other countries or populations. Highlighting these study demographics within the study table (Table 2) was a conscious choice to bring awareness to this bias to help highlight inequalities in health research. Demographics on socio-economic status and cultures could also be considered to improve generalisability, however often this information is not reported within studies. Barkensjo et al.’s (2018) study included within the review goes some way to considering perceptions of safety for patients from marginalised groups, however this was only one out of 11 included studies focusing on this.

Threats to psychological safety may be perceived differently by different ethnicities due to issues such as systemic racism. Although not included within the study due to not meeting the inclusion criteria of being within a hospital setting, Bruce et al.’s (2022) findings noted injured Black men accessing trauma centres experienced stigma from and perceived healthcare workers to be less empathetic due to the ‘mechanism of their injuries and their identity as Black men’.

This also raises the issue of how other marginalised groups may experience safety within hospital settings. Mikkelsen et al. (2015) conducted a qualitative study on patients with alcoholic liver disease and their limits and supports following surgery. The predominant theme amongst interviews was ‘Struggle for preservation of identity as a significant individual’, suggesting stigma and preconceived bias amongst healthcare professionals and within society to affect a patient’s care.

Although generalisability and validity is important for literature reviews to consider, another possible limitation of this review is that there is no explicit information on what kind of healthcare systems the studies are within. This therefore raises the question of how replicable the findings of patient perceptions of safety are within a British healthcare system, particularly as the review was being conducted from the UK. As a nationalised healthcare system, threats to psychological safety may be different as opposed to those who pay for their healthcare through insurance, such as in the USA, or they may also be different if the country in which the research is conducted in a different healthcare system.

## **Future Research and Clinical Implications**

Healthcare staff and systems could implement these themes into everyday practice to improve patients’ perceptions of care. For example, promoting and enabling reflective spaces for staff may improve staff satisfaction with their work, and this in turn may create more positive interactions with patients. This could be facilitated by psychology colleagues, however this may not be available in all healthcare settings.

Having an organisation that promotes taking breaks and helping to manage burnout through effective leadership and staff retention also appears key, in order to

In the future, further research should be conducted on patients’ perceptions of safety within hospital from people within marginalised or stigmatised groups, and within specialised treatment areas.

## **Conclusion**

This literature review sought to understand the main factors contributing to patients feeling psychologically safe within the physical health hospital environment, as perceived and/or experienced by patients within physical health care settings, and adds to the literature currently available on patients’ perceptions of safety within physical health hospitals. This was conducted through literature searching and thematic synthesis of the pieces of research literature. The main themes findings of ‘Communication With Staff’, ‘Connection and the Effects of This’ and ‘Control Over the Situation and Self’ encompassed ten subthemes, and provide some insight into the factors that contribute to patients’ perceptions of safety. Factors such as support from others, information sharing and staff presence are expected to be standard practices of care, however importance must be placed on how this is received by the patients in receipt of this. Choices over autonomy and isolation can be patient led aspects of safety, and giving an individual choice over how they wish to proceed with or receive care could greatly improve their perception of how safe they are within the environment. Adaptations to physical environments, such as sensory aspects and organisation, could affect how safe patients feel within hospital settings.

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# **Paper 2: Empirical Paper**

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| **Patients’ perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury** |

Word count: 7938

(Excluding tables, figures, references and appendices)

This empirical paper has been prepared in accordance with author guidelines for *Spinal Cord*. The author guidelines are in Appendix 3.

This paper broadly follows author guidelines for *Spinal Cord* however further editing and formatting will be completed prior to submission to the journal.

**Abstract**

**Study Design**

Eight qualitative, semi-structured interviews were conducted with participants who have experienced acute hospitalisation following a spinal cord injury.

**Objectives**

To gain patients’ perspectives of psychological safety within the acute phase of hospitalisation following a spinal cord injury, with the aim of influencing clinical practice in the future.

**Setting**

Interviews took place within a specialist spinal rehabilitation unit in the Midlands, UK.

**Methods**

Eight participants completed a semi-structured interview within the hospital which was recorded on an approved encrypted device for transcription and later analysis. Interviews lasted approximately 41 minutes. The age range for participants was between 52-80 years (M=64). Data were analysed using Reflexive Thematic Analysis (Braun & Clarke, 2022).

**Results**

Four themes were generated from the data: *Staff attributes and interactions, Availability of resources, Perceptions of self* *and autonomy* and *Impact of others on the ward.* Participants described how each of these themes contained aspects that affected how they perceived their safety whilst in the acute phase of hospitalisation.

**Conclusion**

This research focused on spinal cord injury patients’ perceptions of psychological safety and expands on current available research on perceptions of safety within physical healthcare settings. This has clinical implications for healthcare professionals, patients hospitalised with such injuries and future research.

## **Introduction**

There are approximately 2,500 new spinal cord injury diagnoses a year within the UK (Aspire, 2019); this estimate includes traumatic injuries resulting from accidents and non-traumatic injuries, such as illness. Following a spinal cord injury, there is often a lengthy period of time within acute care, and later, rehabilitation wards, when the individual is medically stable (Fehlings et al., 2017). Within the UK, the acute care period is within non-specialist general hospitals. This phase often necessitates a period of bedrest of up to six weeks following injury, which can be a psychologically taxing time for individuals. Psychological challenges within this time include changes in perception of self-concept, such as how an individual perceives themselves and where they belong socially, their achievements, physical abilities, and their privacy and independence (Nigam et al., 2009).

There is no one agreed definition of what psychological safety is, but can be considered in terms of Maslow’s (1943) hierarchy of needs with physical safety and access to care being the basis on which other needs can be met. Psychological safety can be defined as a state where an individual feels able to take risks and experiment without fear of judgement (Schein & Bennis, 1965; Newman et al., 2017; Edmondson & Lei, 2014). Hunt et al. (2021) suggested that safety can be considered as being treated in a dignified manner and being encouraged to exercise autonomy. Feeling psychologically safe enables an individual to explore their physical environment as well as taking positive risks (Wanless, 2016), can help optimise recovery (Cutler et al., 2020), and reduce feelings of anxiety, depression and promote post-traumatic growth (Morton et al., 2022). As an individual is learning to adjust to the changes in their body following their injury, feeling psychologically safe may have a role in coping with, and later getting the most improvement out of, hospitalisation.

Perceptions of safety have been researched with different clinical populations in order to better understand patient experiences and subsequent suggestions for future healthcare; Cutler et al. (2020) examined how physical environment influenced perceptions of safety for participants in acute mental health settings. This was explored through naturalistic enquiry, with 15 service users, and suggested privacy and meaningful activities were amongst the factors that contributed to feeling safe. Other research conducted in mental health settings on participants’ perceptions of psychological safety focused on staff experiences of what contributes to patient psychological safety, with lack of communication and poor staffing being contributing factors to patients feeling unsafe (Hamaideh, 2017; McGarry, 2019).

Within acute physical health settings, staff experiences of patient psychological safety have been explored. Mohammadi et al.’s (2020) qualitative study involved 17 health professionals working with individuals with COVID-19. This study suggested that having ‘“respect for dignity”, “comprehensive support” and “peaceful environment”’ (p.787) contributed towards their perceptions of psychological safety for patients. Again, although useful to consider, especially within the context of physical health settings, it must be noted that this is a staff experience study and the perspectives of patients in such settings were not explored.

A quantitative study by Wolosin (2006) based within the USA analysed over 600,000 patient safety ratings across acute care hospitals. The study suggested that communicating clearly with patients (especially in regards to medicine), responding quickly to complaints and attending to an individual’s emotional and spiritual needs to be amongst the items that contributed to patient safety ratings, suggesting that these elements may add to psychological safety within acute hospital settings. A thesis by Sinclair (2019) also explored patients’ experiences of safety in acute hospital settings with a view to informing the validity of the King’s College patient safety measure. This was a questionnaire based study, including 15 items rated on a Likert scale according to importance of making the patient feel safe. Within the study, open ended questions were also asked which highlighted items such as poor communication between healthcare professionals and the patients and poor staffing levels as contributors to feeling unsafe in the ward setting. These studies both demonstrate possible areas impacting on patients’ perceptions of safety that may benefit from further exploration, especially in regards to spinal injury as these are typically longer hospitalisations than those within the Sinclair (2019) study, which had an average of 4.5 days.

Within spinal cord injury research specifically, a systematic review considering the psychological resources within adjustment to spinal cord injury noted higher self-efficacy and self-esteem to be indicators of better outcomes for adjustment, such as more positive mental health and wellbeing (Peter et al., 2012). Although not specifically investigating perceptions of safety, these factors may contribute to an individuals’ sense of safety (Frazier et al., 2017). There has been recent investigation into how provision of information impacts patients (Cogley et al., 2021); this qualitative research was conducted with seven individuals with a spinal cord injury and six family members of individuals, using semi-structured interviews and reflexive thematic analysis. Cogley et al. (2021) suggested that ongoing information giving, clear communication and being realistic yet hopeful in communicating prognoses were important to the patients. Additionally, Scheel-Shailer et al. (2017), studied patients’ experience of decision making after spinal cord injury and ways in which the injury impacted on psychological safety, in that an individual needs to feel safe enough to express opinions as well as having open communication for decision-making.

There does not appear to be any qualitative research regarding individuals’ perceptions and experiences of psychological safety within acute hospital settings following an acquired spinal injury to date. Therefore, it was necessary to explore the topic from the perspective of those who have experienced a spinal injury. Collecting data from individuals directly helps research to be more relevant to those with the condition, as well as being more accessible and more understandable (NHS Health Research Authority, n.d.), and further informs and enhances practices of healthcare professionals working with this population (Middleton et al., 2014).

The research question was: What are patients’ perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury? The aim for this study was to explore perceptions of psychological safety within a spinal cord injury population, in the hope that this would provide information on what contributes to psychological safety within such settings, and suggest improvements for the future.

## **Methodology**

### ***Epistemological position***

This research is written from a constructivist stance, and therefore assumes that the language used by participants allows them to construct and create meaning from their lived experiences, by which patterns of shared experience can be analysed by the researcher (Braun & Clarke, 2022). In using this stance, the data was understood to represent a concept the participant was sharing subjectively rather than an objective representation of the reality (Appleton & King, 2002; Braun & Clarke, 2022). The researcher has had own recent personal experience of being an inpatient in hospital for a physical health condition, as well as professional experience of working within the setting in which the research took place. Reflexive thematic analysis acknowledges that these experiences cannot be separated from the researcher and therefore influence interpretation of results, and supervision and reflection forms a key part of the research process (Braun & Clarke, 2022). Within this research, experiences were reflected on and discussed within academic and clinical supervision as well as within a reflective log (extracts within Appendix 4), in order to maintain awareness of the researcher’s personal views, assumptions or biases whilst analysing the work, and to retain research integrity during analysis (Braun & Clarke, 2022).

### ***Ethical considerations***

Due to the study being conducted within an NHS site and with current NHS patients, ethical review was necessary. An Independent Peer Review (IPR) proposal for the study was approved by Staffordshire University’s Research Ethics Committee (see Appendix 5 for approval letter). Following this, approval was sought from the NHS Health and Research Authority (NHS HRA). Approval was granted for this study in August 2022 by the Research Ethics Committee (Appendix 6), and HRA (Appendix 7). A risk assessment and mitigation plan was conducted and submitted for ethical review; potential risk to participants was that of distress in recalling traumatic events, which was mitigated with support within the hospital and contact details for support outside of the hospital.

Interview data was stored on an encrypted device, and audio recordings were deleted following transcription. Consent forms were stored securely and separate to any participant data within the study’s sponsor site. Participant demographics were grouped in order to protect identity of the participants. Further monitoring of adherence to the proposal and maintenance of a research site file was completed and overseen by the research leads within the hospital trust.

### ***Interview schedule***

The semi-structured interview used was constructed by the research with help from a clinical psychologist within the field, who formed part of the research team. The interview was based on similar studies within related fields (Mohammadi et al., 2020; Ricci-Cabello et al., 2016), with points to cover within discussion if these did not naturally arise within conversation. The Interview Schedule with a list of interview questions is in Appendix 9.

***Recruitment***

Potential participants who met the inclusion criteria for the study were identified by a member of the research team within the clinical setting and brief verbal information about the research aims and methods was provided. If a potential participant expressed interest in receiving more information, a participant information sheet (Appendix 10) was provided. Potential participants were given up to a week to consider whether they wished to participate, with the opportunity to ask any questions to the member of the research team via the contact details provided. If the participant notified a member of the clinical research team that they wished to participate, a suitable date and time was arranged with the participant and a confidential clinical space booked within the hospital for this. All research interviews took place on the hospital site to accommodate participants’ physical needs (e.g., meals and medication) for their rehabilitation programme.

At the arranged interview time participants were offered the opportunity to read through the information sheet again with the researcher. The participants were then verbally asked for consent to participate again and reminded of their right to withdraw from the study. Consent forms (Appendix 11) were completed by initialling each item and signing; in the case of limited hand movements for signing consent, an independent witness (a member of the hospital staff not connected to the research) was asked to be present for the verbal consent and sign on the participants’ behalf, with the participant present. During this stage, there were no participants that requested to pause prior to consenting.

**Figure 1.**

*Eligibility criteria for study.*

|  |  |
| --- | --- |
| Eligible for participation criteria | Rationale for criteria |
| Adult (18+ years) | Responsible for own informed consent. |
| Currently within rehabilitation ward | Post-acute phase of the injury having been sustained and therefore perspectives shared were retrospective and not current. |
| Assessed by psychology team | Psychological support in place for individual if necessary. |
| Fluent written and spoken English | Ability to read information regarding participation in the study and participate in verbal interview.  No funding available for translation services. |
| Capacity to give informed consent | Adherence to ethical concerns. |

**Participants**

All participants were recruited from one specialist rehabilitation hospital site, however participants had attended different hospitals during the acute phase of hospitalisation. Participants were recruited in-line with the eligibility criteria detailed in Figure 1. One participant was identified for potential recruitment and provided with information about the study, however declined to take part when approached by the researcher, with no reason provided. A total of eight participants were recruited to the study and completed the interview.

Demographic information for participants is presented in Figure 2, and presents age range to retain participant anonymity. Age range was between 52-80 years, with an average age of 64 years. Injury level refers to the area of the spine that sustained the injury, which along with completeness of injury information helps provide some guide on the physiological impact of the injury. Corresponding participant pseudonyms have not been included due to anonymisation.

**Figure 2.**

*Participant demographic information*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gender** | **Age Range** | **Injury level** | **Completeness of injury (Complete or Incomplete)** | **Time since injury at time of interview** |
| Male | 50-59 | Cervical | Incomplete | >6 months |
| Male | 70-79 | Cervical | Incomplete | 0-3 months |
| Male | 60-69 | Cervical | Complete | 4-6 months |
| Female | 60-69 | Cervical | Incomplete | >6 months |
| Male | 50-59 | Thoracic | Incomplete | >6 months |
| Male | 50-59 | Cervical | Incomplete | 4-6 months |
| Male | 70-79 | Cervical | Incomplete | 4-6 months |
| Female | 80-89 | Thoracic | Complete | >6 months |
|  |  |  |  |  |

**Data collection**

Semi-structured interviews ranged from 30 minutes to 54 minutes, with an average time of 41 minutes.

Interviews were audio recorded on an NHS encrypted laptop and approved recording applications. The interviews were then transcribed and analysed by the researcher. During this process, an initial interview with one participant was lost due to recording errors. To rectify this, the participant was informed and consented to a second interview. Data from two further participants was impacted by low quality audio; the data that remained has been included within the analysis. Following the interview, participants were provided with a debrief sheet (Appendix 12). Participants were given the opportunity to withdraw data for a month following their interview by informing any researcher; no participant chose to do this.

**Analysis**

Reflexive Thematic Analysis (RTA) was used to interpret the data collected (Braun & Clarke, 2022). This approach was chosen for its flexibility in acknowledging themes from previous similar research (Cogley et al., 2021; Geard et al., 2020) within analysis. This inductive approach also allowed space for considering latent as well as descriptive meanings within the dataset, which fitted the research question of gathering patients’ perceptions of their experiences.

This followed the six step process:

1. Familiarisation with the data. This step was inclusive of the researcher collecting the data personally, completing the transcription process, re-listening to the audio data and re-reading the resulting interview data.
2. Coding of the data. The data were reviewed and parts that pertained to the research question or seemed relevant were noted with initial codes to indicate the potential interest or meaning. These were compiled within a separate worksheet with corresponding quote data.
3. Generation of initial themes. Quotes that were coded as similar were grouped and themes that linked the information were generated.
4. Theme development and review. Initial themes were considered and reviewed to ascertain if the information within the data was captured as fully as possible.
5. Refinement of themes. This was conducted through supervision of drafts of the data analysis with academic and clinical supervisors.
6. Reporting of data.

# **Results**

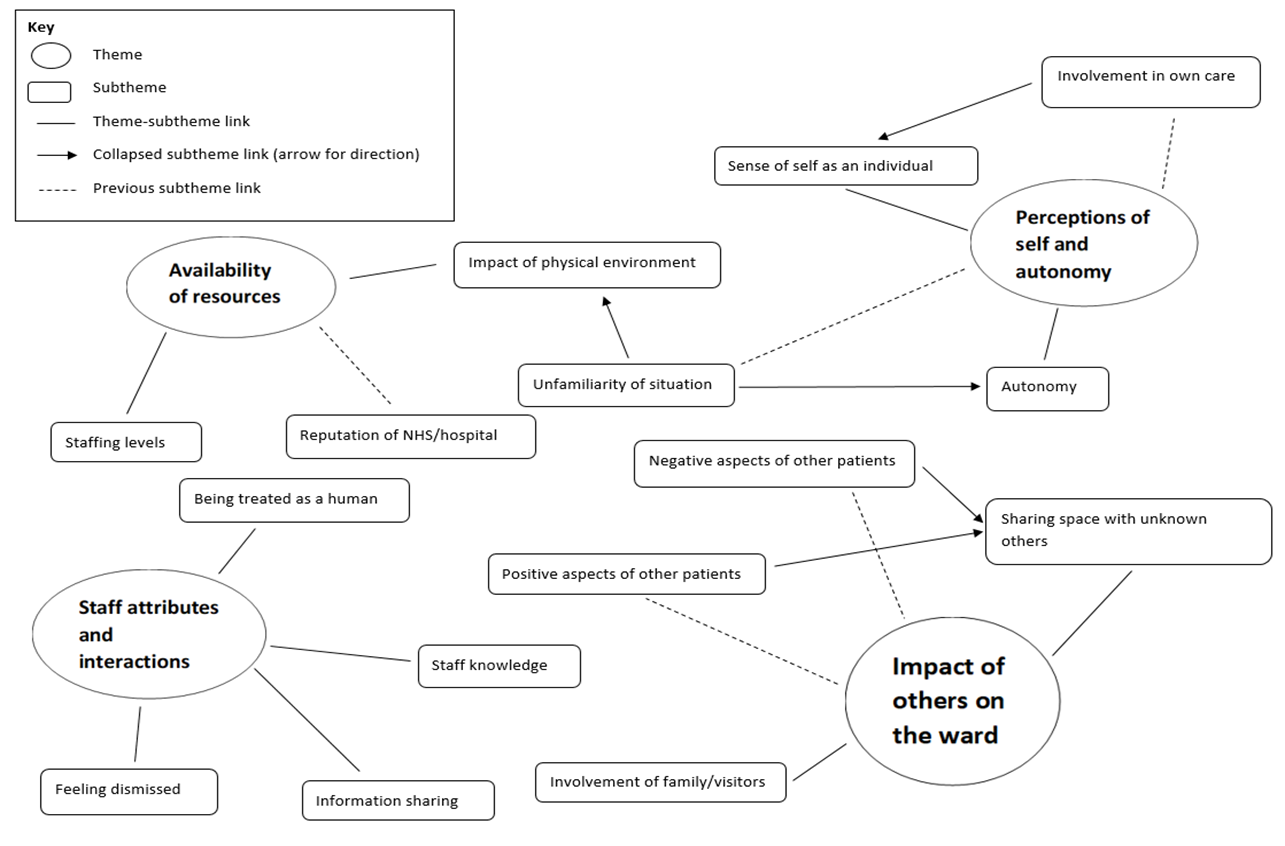
The analysis of the data yielded four main themes and ten sub-themes represented below (Table 1). Figure 3 represents the theme map; a previous working theme map prior to refinement can be found in Appendix 13.

**Table 1.**

*List of themes and sub-themes*

|  |  |
| --- | --- |
| Theme | Sub-themes |
| Staff attributes and interactions | Being treated as a human |
| Feeling dismissed |
| Staff knowledge |
| Information sharing |
| Perceptions of self and autonomy | Sense of self as an individual |
| Autonomy |
| Impact of others on the ward | Sharing space with unknown others |
| Involvement of family/visitors |
| Availability of resources | Impact of physical environment |
| Staffing levels |

**Figure 3.**

*Theme map, including revised themes*

## **Theme 1: Staff attributes and interactions**

This theme pertained to how staff’s qualities and approaches to work influenced perceptions of safety. This included subthemes of Being treated as a human, Feeling dismissed, Staff knowledge and Information sharing.

**Being treated as a human**. As one participant, Steve, noted, the question for participants within hospital was“how safe do I feel in the care of strangers, because that’s what they are”. Qualities that helped participants feel safe within hospital included dignity and respect towards individuals: “All the hospital, all the nurses, all the doctors. Even my consultant. They were very, very good. Treated me with dignity and respect” (Sheila). Other qualities that affected this perception of safety for participants were showing kindness and care towards their patients: “They were always showing kind[ness] and caring”(Sheila) and “They were organised. They were diligent” (Ken). Displaying diligence and proactive management helped patients have more space to focus on their goals: “You don’t have to worry. They do all that for you... (LR: What does that leave space for?) I think about all the stuff I want to achieve” (Ken). Other positive qualities included showing investment in the patient’s progress, which had a positive impact on feelings of reassurance and wellbeing:

They were visibly pleased that we were making progress. Yeah. And it's, in terms of psychological reassurance for a person in a fairly dire situation, that's, I think, really important. (Ken).

Having interactions on a human-human level, rather than patient-healthcare professional, was also noted as important. Luke observed that these small interactions helped to provide a small break in the day: “Just the fact that you can have a laugh with them. You can have a laugh and break the day up.” Staff also recognising that “it’s a small thing to you [staff], but a big thing to me [patient]” (Steve) was important in helping individuals feel safe and looked after, which included acts of non-medical care:

When I first came to the hospital, I had a real guilt trip about, I thought that you would only have their attention or assistance for medically derived situations, so asking them to put your socks on or turn your telly round or whatever. I thought it wasn’t really in their remit. But then you realise that their remit is really to assist you, in your care, safety, happiness, mental and physical. Once you learn that, your hospital stays is a lot better. (Steve)

**Feeling dismissed.** Negative attitudes observed by participants affected perceptions of safety when staff were rude to or visibly annoyed with patients, such as when an individual was ringing the buzzer for assistance when on bedrest. Participants stated:

Some of the staff, particularly nights, were rude. They shouted at you for ringing the bell or the buzzer, they were busy, things like that, and not answering the buzzer for hours. (Frank)

They all at [first hospital] seemed to be so cross… I dreaded it if I dropped anything and if I buzzed at night, they were, I suppose they … didn't really want to be buzzed at 3:00 AM. (Janet).

This reaction also resulted in a participant noting that they would wait to ask for help, sometimes until the morning, which compromised physical safety such as in the case of skin integrity when waiting to ask for a pad change or to be moved:

Because when you can't move, you need realigning, and they did come around and realign you, but you know, sometimes you're not in the right position and you’re uncomfortable... so you have to call them again because something’s moved or something. And there’s just no way, it’s so painful that they have to come back and they don't...So sometimes I used to just, and not just me, a lot of people used to just lie there and just be uncomfortable.(David)

Staff members talking to colleagues about patients whilst in the patients’ presence was also noted by participants to have a detrimental effect on wellbeing, as Steve discussed: “I had an experience when someone was feeding me, and their superior walked past and asked them [how] long they're going to be, which I was disgusted with”. Janet experienced a doctor using medical terminology instead of person-first language, and reported that “they all stood around on one occasion, and consultants said looking at them all, ‘that's a thing with tetraplegics they always have to do’ or whatever and I thought, Oh, I’ve got a label on now saying tetraplegic”. In both of these instances, the participant reported a negative effect on their mood and a sense that they were not treated with dignity.

**Staff knowledge.** The knowledge of the staff and how this was conveyed to others on the ward had an effect on patients’ perceptions of safety. Staff not listening to patient concerns regarding physical issues was reported by participants to negatively impact their perception of how safe they felt within the hospital. Staff noting that they did not share the concerns or dismissing the concern as they had more clinical experience was noted by two participants: “She goes, she said, ‘Just go to sleep. I've been a nurse for 27 years’. She says ‘I know what I'm doing’”(David). Additionally, another participant stated that when their catheter was blocked and the nurse they reported it to dismissed concerns, this resulted in the individual not only feeling worried about their physical safety but also feeling angry and dismissed. Ken noted that they reminded themselves that the staff complete these tasks every day, and that they “just [had] to rely on their skill”, which appeared to contribute to a feeling of helplessness and lack of control. Other participants also noted that when staff were unsure or not as confident, this affected how safe they felt in their presence (Philip).

However, having experienced members of staff sharing expertise and knowledge was a useful resource for Steve and provided a sense of reassurance: “But because the nurses see people go through the system so much, they’re as close to understanding as they’re ever going to be without physically going through it.”

**Information sharing**. All participants referenced the information provided to them and the manner in which it was provided as integral to their experience of safety. One participant noted that the information provided prior to surgery was comprehensive, and although they felt reassured by this, this did not eliminate the apprehension of going into surgery (“Before I had the operation they tell you, they say to you what can happen, so this is what can happen. They explain.”- Philip). Another participant noted that they felt that they had been given information in an accessible way: “They explained things to me because I'm not, I'm not medically you know, medically I don't know anything” (Sheila).

One participant noted the impact of taking time to explain what was happening and why, and how this made them feel reassured and saved them from overthinking a situation or procedure: “Yes, seconds. Yeah, seconds and it can save… but it can save the hours and days of fretting and mulling and thinking over it”(Ken). When staff did not take the time to explain information, this negatively affected senses of security.

You know, they, they half tell you something, or they do want you to do something, the ward staff, without explaining why. I like to know what's going on, and that kind of made me feel a bit insecure and quite cross. (Ken)

## **Theme 2: Perceptions of self and autonomy**

Sustaining a spinal cord injury, with necessitated lengthy hospitalisation and life-changing effects affected the participants’ view of themselves and their ability to live autonomously whilst receiving acute care. Sub-themes within this theme included Sense of self as an individual and Autonomy.

**Sense of self as an individual.** When asked about the early days of being in hospital following their spinal cord injury, six out of the eight participants noted that there was autobiographical information missing, with one noting that it was a “blur”; this was a sentiment echoed in other participants’ narratives and attributed to shock, strong painkillers and the monotony of hospital (“I don't remember anything except that I came round in intensive care and I had a lot of morphine” – Janet; “And what I'm saying is what they told me that they resuscitated me” – Sheila). This lack of knowledge about their own story may have impacted some of the processing of the events and lead to reliance on others to inform them what happened.

Another participant talked about perceptions of self and self-image that were affected by the injury with one participant describing a response to their physical changes: “That is upsetting really because I used to have [describes body prior to injury]. And now it’s [describes body now]. I can't bear that really.” (Janet). This change in self-perception appeared to result in the individual feeling negatively about themselves as they adjusted to the changes in their body. Steve spoke of how they prefer to present themselves, and how having this encouraged and enabled by staff was something that made them feel more secure and more like themselves (“I’ve always been very well presented and I don’t want that to stop in hospital. People around you that want to help keep your standards. That helps you feel safe as well.”)

There was also discussion of own coping skills and how this impacted senses of safety. Philip and Sheila spoke of their faith, and how this helped them through the hospitalisation period. Other traits such as being practically-minded was noted to be useful by Ken, as this enabled them to focus on the next goal within hospital. Luke noted that their family and friends were part of their coping skills that helped them get through the experience of hospitalisation.

Being actively involved in their own care and seeing progress was something that impacted feelings of safety for the participants interviewed.

Achieving goals and seeing progress for themselves was something that all participants noted to be helpful in feeling psychologically well: “But when I do achieve a little baby something, it's very cheering” (Janet). Also, having hope for the future due to seeing such progress was vital for one participant to be able to cope with the hospitalisation period: “…just got on with it. Got into the routine. Didn't think too much about the consequences. Because I knew I was going to get well enough from the first two or three weeks” (Ken).

**Autonomy.** For all participants, adjusting to having to depend on others for their care needs whilst in hospital was a significant change and challenge, and one that impacted psychologically, with feelings of being scared noted: “I'm totally dependent on these people here and it's really scary.” (Ken).

And I did six weeks go completely flat on my back bedrest. So all I could see of the world is, you can't see faces, people come and sit down next to you and talk to you. You can't see faces. You can't recognise people unless they're right over your head. Which was difficult because they're the people looking after you. I was completely dependent on the ward staff. (Ken).

Similarly, two participants (Steve and Ken) spoke about how vulnerable they felt prior to mobilisation, due to not being able to control or access their environment independently: “Before mobilisation, is the most dangerous and worrying part from the patient's point of view” (Ken); “You can't go to anyone and you’re reliant on the buzzer” (Steve). This dependence on others and lack of choice as to when others could be accessed impacted how safe the individuals felt in the hospital environment.

Steve noted that small choices had been taken away when in the acute phase of their hospitalisation: “I’ve lost my choices. How much do I have, how much food I put into my mouth now, I’ve lost that choice”. In losing these choices, the individual reflected on how important ‘small things’ were to them, and how any opportunity to exercise choice made them feel safer within the environment, and resulted in them feeling reassured that they were being treated as an individual and had some control over aspects of the situation.

Hospital being an alien environment was noted by Steve (“Because it's not where we go very often, is it?”), with the uncertainty of not knowing what to expect adding to participants’ sense of a lack of control within the situation. This unfamiliarity and lack of personal points of reference for the experience impacted how safe the individual felt as they were unsure what was to be expected in the situation. This uncertainty and its effect on feelings of safety was reflected on by Ken, with more knowledge about the situation being associated with feeling safer (“If there’s fear, it’s fear of the unknown really. And the more you know, the less you fear. And the safer you feel.”). Frank also noted that a lack of a point of reference for the experience affected how they processed the experience:

At the time you're not really analysing things. You also, you haven't got something to gauge. It's the first time I've been in hospital as an inpatient, first time I've ever had a spinal injury, first time I'm ever recovering from something in steps. (Frank)

## **Theme 3: Impact of others on the ward**

As hospital care is a shared environment, the impact of others on the ward was considered by participants. This theme included subthemes of Sharing space with unknown others and Involvement of family/visitors to create some feelings of safety on the ward.

**Sharing space with unknown others.** A positive aspect of sharing space with others was reported to be the camaraderie that could be experienced, such as one participant (David) reporting that they stayed up to play cards with another patient on the ward one night. Having moments when the participants did not feel like a ‘patient’ but like a ‘human’ were key to feeling psychologically safe and cared for within the environment.

All participants recounted how, if they were unable to reach their call button or shout for help, other patients in the space would press their call buttons on their behalf (“And you either shout, or yell, or hope one of the other patients in the ward is awake so they can press their button” – Ken). Being able to rely on others to help when the individual was unable helped the participants to feel safe. Sheila recounted how one fellow patient on the ward helped her with her food: “And she said I'm going to help you finish that food. And she spoon fed me.”

During hospitalisation, shared bays are common, which all participants referenced when considering their perceptions of safety. Ken recounted a negative aspect of sharing a space with other patients and witnessing abuse towards staff: “Verbal abuse, physical abuse. If they could catch a nurse within range. They either give her a punch or a kick. Absolutely awful.”Being in such an environment impacted their perceptions of how psychologically safe they felt, as well as concern for the safety of the staff.

Others asking unwanted questions was noted by Janet to be something they found affected their mood: “Do you think you'll ever walk again? And it really dawned on me. No, I very probably will never walk again. So then I cried a bit. How tactless can someone get?” Janet reflected on how having the option of a single occupancy room was preferable, as this offered some choice over whether to interact with others.

**Involvement of family/visitors.** Participants noted the impact of having visitors on the ward. For one participant (Philip), their visiting hours remained restricted due to COVID restrictions on the ward, and they were limited to two hours a day. They noted this was ‘hard’ for them psychologically and that visitors such as family helped to improve their mood and outlook (“And it was Covid, and that one visitor comes to visit for 2 hours everyday … And it was. It was hard.”- Philip). Having no restrictions on visiting was seen as a positive thing by Frank: “I mean, quite regular visitors were allowed in as there was no restrictions really on visitors to speak of. So they were just allowed to come in anytime they wanted. So that was good.”

Other participants reported that having family visit for longer periods enabled family to become more involved in their care, increasing how safe they felt within the hospital. Participants noted examples such as family completing physiotherapy exercises with their loved one under the guidance of the physiotherapist (“My physio was there and they’d be watching her, so that on the days they didn’t come, she could do the physio. Well, certain parts. She could massage my hands.”– Luke). Being able to be present for meetings and for the staff to be able to get to know family members and for them to feel like they are being cared for and supported too, as well as the patient. The presence of family and friends appeared to enable the patient to feel safer within the environment due to transparency of information sharing and collaborative work, as noted by Ken: “And if I was worried about anything, they'd go away and talk to the ward staff and find out exactly what we were doing and why we're doing it”.

## **Theme 4: Availability of resources**

This theme included sub-themes of Impact of physical environment and Staffing levels.

**Impact of physical environment.** Having separate spaces within the hospital such as canteens and outside spaces were seen as positive, and the presence of medical staff if necessary was seen as a reassurance (“The garden spaces were nice to escape to cause it's not like a hospital environment.”; “I thought I'm just in a canteen, anywhere in the world. I knew there was, I felt safe because there was medical staff there.” – Steve).

Having access to necessary equipment such as soft, non-hand activated buzzers was important; David recounted being unable to have access to this resulted in having to shout for help (“And I couldn't press a button and I asked for a softer one and they couldn’t find one. So I had to shout out in the night”). The presence of physical safety measures such as sides on medical beds and correct mattresses increased senses of safety, as noted by Steve (“How safe do you feel in hospital? Well, really to answer that I feel really safe because I've got rails on the side of my bed”).

Within the physical environment was also hospital routines. Participants noted that the impact of bright light within the bays at unexpected times (such as at night) was frustrating and affected sleep at a crucial time in recovery:

They've obviously got all the lights on, but just leave the doors open. So the place was flooded with light. So lack of control of the environment caused the frustration… And at that stage in your recovery, the early acute stage, sleep is probably one of the most important things for healing. (Ken)

The impact of hospital routines also resulted in one participant feeling infantilised: “You didn’t have a say, they put you into bed... So yeah, yeah, made you feel like a child” (David). This impact of shared spaces and of hospital routines having precedence over individual wellbeing contributed to frustration and to a sense of a lack of autonomy for the participants.

The lack of stimulation whilst on bedrest was also part of the unfamiliarity of the situation and a challenge for participants, with this period resulting in increased anxiety: “And it’s what happened, I couldn’t do anything, just lying there, staring at the wall, lying there with the thoughts going through my head, will I be able to walk?” (Philip). This was also noted by Participants 5: “Yeah, six weeks proper backrest, bedrest looking at the ceiling”.

Nights were also noted to be more difficult than days, with participants noting that the impact of the environment and the different staff on nights affecting their sense of safety (“So yeah, nights were awful at the [first hospital]” – Frank; “I found the nights very hard. I wasn’t looking forward to the night staff coming on. It used to make me feel apprehensive you know, wondering which of couple were coming on” – David; “And it's worse in the dark somehow” – Janet).

**Staffing levels.** Patients’ spoke of their awareness of the pressures the systems are under and their perceptions of how these impacted them and their safety. As Frank noted: “Staffing levels were bad, nowhere near enough staff.”

Awareness of the process and business model of healthcare within Britain was evident for one participant. They noted that they felt like a “box to be ticked” (Steve), and regarding certain activities such as turning the participant and being fed: “So we've just become a KPI [key performance indicator]. The whole process. We're not humans anymore” (Steve). Feeling like they were on a ‘to-do list’ was something reported by other participants, and the awareness of this made them feel less cared for. “You know, they come in, they whack the breakfasts out and they go on to the next bay. Because they've got so many people to feed in a certain time.” (Ken). The dehumanisation of people’s needs due to systemic pressures resulted in individuals feeling devalued and less safe in the environment, as they were unsure if their basic needs would be met in a dignified and timely manner. This rushing of tasks was especially difficult for participants to deal with in the case of meal times. One participant described watching their breakfast “go cold” (Ken) as they were unable to reach it and feed themselves. This was a risk to physical safety due to risk of not getting enough nourishment, but also led to risks to psychologically safety in not feeling cared for adequately.

The impact of the lack of adequate staffing was noted by all participants. Having an understanding of why this was occurring seemed important, and participants were aware of the climate within the NHS regarding staffing: “But you can understand why they do it [rush meal-times] because they're understaffed and really busy” (Ken). On some occasions, this meant participants having to manage how they were cared for:

In my first hospital, unfortunately, if I didn’t direct it, no one else was going to. Which is not the right way to direct your own care but I had to because if I didn’t, they didn’t and things wouldn’t get done. (Steve)

Although aware of the pressures on the system, this did not negate the feelings of responsibility shouldered by the participants in regard to having to direct their own care. Feeling like they had to do so, otherwise they would not receive care, added to the sense of feeling unsafe within the environment.

# **Discussion**

As noted, spinal cord injury necessitates intense care and often long periods within hospital. The unique nature of the injury and treatment, namely, bedrest and changes in physical abilities, presents a challenge to the individual in how to retain a sense of safety whilst being in a physically vulnerable position with little autonomy or stimulation, and potentially with unmet or neglected needs when in a busy, acute and non-specialised environments. This research focused on patients’ perceptions of psychological safety and expands on current available research on perceptions of safety within physical healthcare settings. This research also highlighted that psychological safety is a personal concept for each individual, and what contributes to one person’s sense of safety may not be the same for the next; further demonstrating that care for each person must be collaborative and individualistic.

The theme of ‘Staff attributes and interactions’ contained subthemes of Being treated as a human and Feeling dismissed. Participants’ feelings around this supported previous research into psychological care within spinal cord injury that also suggested that staff being perceived as bored, irritated, or superior provoked feelings of fear and anger within their patients (Partridge, 1994). Furthermore, interactions with staff such as them being dismissive about health concerns raised, were described by participants in the current study as impacting their sense of safety, which mirrored research findings in other studies on physical health and patient safety (Kenward et al., 2017). Participants also spoke of how information sharing impacted their sense of safety positively; this included sharing with their support networks, explaining procedures and using language at the ‘level’ of the patient. This is congruent with other research completed with spinal injury patients and the impact of information-sharing (Cogley et al., 2021).

Within the theme of ‘Perceptions of self and autonomy’*,* the changes in self-concept and reliance on self and a new dependency on others was concurrent with other research in the field (Kaiser & Kennedy, 2011; Partridge, 1994). Healthcare professionals being able to support patients with these changes and respond in an empathetic and encouraging manner could have an impact on how psychologically safe the patients feel following their injury; for example, acknowledging the difficulty in adjustment and encouraging choice and autonomy where possible. Previous research conducted with intensive care unit patients in the USA (Hupcey et al., 2000) suggest that having autonomy and choice over certain aspects of care increased perceptions of psychological safety. This same perception was reflected in the participant interviews in the current study.

It is accepted that patients within hospital will, at times, be required to share space with other patients. The impact on feelings of safety for patients can be either positive, in the advice and camaraderie that they can provide, or negative, in terms of threats to physical and psychological safety in terms of patients abuse towards others, and threatening language or behaviour directed predominately at staff. Bertuzzi et al. (2022) reviewed the clinical and humanistic impact of shared accommodation versus single rooms in acute hospitals, and the review suggested that certain demographics (such as men and older adults) may prefer multiple-occupancy rooms to negate feelings of loneliness, whereas others may choose single rooms for more privacy and for less disturbances. These findings appear to be mirrored within this study, with participants having their own preferences on shared spaces. This suggests that individuals having a chance to state their preferences for bays would ensure care is person-centred, however in a public healthcare system this may not be feasible.

It seems particularly pertinent within the current political context to consider the impact of narratives regarding NHS resources and staffing levels on the clinical population, considering nursing strikes and following on from the COVID-19 pandemic (British Medical Association, 2022). By the nature of requiring healthcare, individuals with a newly acquired spinal cord injury are arguably already feeling vulnerable, and being aware of how stretched services are prior to hospital admission appears to compound these feelings for those requiring services.

## **Strengths and limitations**

At the time of writing, no empirical study had explored patients’ perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury. Exploring this research area with individuals affected enabled some understanding of their experiences of feeling psychologically safe (or unsafe) within the acute phase of hospitalisation. An extra benefit of this study was that the individuals often spoke about what helped them to feel psychologically safe within the rehabilitation phase as well, which added to the richness of the data and provided a timeline of how perceptions of safety changed throughout their journeys.

The interview schedule (Appendix 9) consisted of points to be explored if not covered within the discussion naturally. This schedule and its construction did not directly involve the client group being consulted for the study. Including the client group in the process via a focus group may have resulted in different areas to explore (Chalmers, 1995). Initially, a focus group was intended, however due to time pressures of the study following delays with ethical review, this was not feasible; this would be recommended for future research.

Difficulty with recording of data resulted in some data being lost during the process, which may have added depth and richness to the analysis. However, this was overcome by the participant agreeing to a second interview and this contributed to the richness of experiences shared with the researcher.

The immediate time period following a spinal injury was difficult to recall for some participants, due to shock and trauma (Alcántar-Garibay et al., 2022) and/or the effects of strong painkillers at this time. Some participants also experienced hallucinations during this period (Vastano et al., 2022). Although these confounding factors may have resulted in some hampering of recollection of events and perceptions of psychological safety in the immediate acute phase of hospitalisation, due to the length of stay in hospital following a spinal cord injury, it remains possible to gather perspectives on this period.

A further limitation is that of generalisability. As noted, this research was conducted within one research site with eight participants who were between 52-80 years old. Having a wider range of ages may have provided different perspectives. Although more participants may have strengthened the validity of the data, the data was reaching saturation with similar themes throughout the dataset (Fusch & Ness, 2015).

# **Clinical implications**

Whilst highlighting the unique challenges that SCI presents within the acute hospitalisation phase, this research centres the need for greater awareness of what may contribute to patient perceptions of psychological safety, and may help to enhance more focused care plans and a better understanding of safety within this and potentially other clinically vulnerable populations in acute care (Cutler et al., 2020; Hamaideh, 2017; McGarry, 2019).

By gathering patients’ perceptions of safety, and the factors involved, consideration can be given on how to adapt hospital care for patients with a SCI within the acute phase. For example, increasing awareness of the impact of each interaction from staff, being aware of the narratives around healthcare provisions and their impact, and ensuring that patients have control and autonomy over aspects of their care, where feasible (Venesoja et al., 2020). Acute hospital staff could receive training on SCI and the psychological impacts of this, including focus on feelings of lack of autonomy and of vulnerability, to help improve knowledge and increase individualised care for this population. This training could be underpinned by a compassion-focused approach, to reduce the sense of threat within the system and for individuals, and to increase senses of safety for the staff within the system that would enable individuals to move into a space where they are able to learn (Gilbert, 2010). Developing self-compassion and reducing self-criticising inner speak through a compassion-focused training approach may have benefits for healthcare staff and cascade into providing more compassionate care for patients (Beaumont et al., 2016).

On a wider, long-term level, consideration of how to improve physical resources, including staffing levels, to ensure that patient needs are being met in a timely and proactive manner is needed, as well as considering how narratives of the systems’ pressures (and failings) are being portrayed to both the clinical and the wider population (Agnew et al., 2013). Ensuring that pressures of the system such as staffing levels and high workloads are not transferred to individuals requiring care, resulting in them feeling dehumanised, seems especially important. Treisman’s (2021) work on trauma-informed care highlighted how injury and medical intervention is in itself a potential source of trauma, and adaptations to the environments in which people receive care, such as ensuring that others in the environment are regulating emotion rather than escalating, can help create environments that feel safer. This could be achieved by facilitating reflective spaces for staff, and as stated, utilising a compassion-focused approach (Gilbert, 2010), may enable this.

Considerations could also be taken in the future for how changes to the physical spaces could impact feelings of safety, and how future hospital design could influence this. Pilots for trauma-informed spaces such as one within London for women within the justice system (Petrillo, 2021), highlighted how separate spaces/bathrooms, natural light and adaptations for various abilities helped foster a sense of safety within a clinical space.

# **Future research**

One participant reflected that they were very much in a ‘different space’ psychologically following further rehabilitation and time passing since the acute phase of hospitalisation, which they noted enabled them to reflect on different parts of their experiences and how perceptions of safety evolved for them following time spent in rehabilitation settings. Returning to participants at a later date, or an in-depth series of case studies with participants may yield more rich data on the subject of perceptions of safety and how this progresses over time for this clinical population.

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# **Paper 3: Executive summary**

# **Patients’ perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury**

Word count: 2406

This executive summary is aimed at clients with spinal cord injuries, the general population and healthcare professionals working within acute hospital settings with individuals with acquired spinal injuries.

This has been presented to a service user for feedback, as well as consultation with a clinical psychologist in the field. Suggestions on how to present the information, such as pictorially, were implemented.

**Patients’ perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury**

## **Why was this research done?**

There is a lack of research on what affects someone feeling safe within hospital following a spinal cord injury (SCI), despite approximately 2500 new instances of injuries like these being diagnosed each year in the UK (Aspire, 2019). Spinal cord injury is damage to the spine, and can happen through an accident, such as a fall, or through illness, like cancer. Depending on where the damage is in the spine, different bodily functions can be impacted, for example movement of certain areas of the body. SCI results in lengthy stays in hospital; around six weeks is usually spent on bedrest following the injury, often in busy, acute general hospitals (Sheffield Teaching Hospitals, 2021). This stay in hospital can be hard psychologically for people (Nigam et al., 2009), and can feel isolating and boring being separated from home with limited activities due to bedrest. Gaining information on what affects people’s perceptions of psychological safety could help inform healthcare practices and increase the knowledge of both individuals and the people working with them.

**What is psychological safety and why is it important?**

There is no one definition of psychological safety. It can be defined as:

Feeling able to take risks without judgement and feeling supported to do so within an environment, and feeling like you are being treated with dignity and being encouraged to have choice.

(Schein & Bennis, 1965; Newman, Donohue & Eva, 2017; Edmonson & Lei, 2014; Hunt et al., 2021).

Feeling psychologically safe can:

Help protect from stress, depression and anxiety (Morton et al., 2022).

Help someone explore their environment more and take more measured risks, helping to optimise recovery (Wanless, 2016; Cutler et al., 2020).

There is research within physical health hospitals that suggests poor communication amongst staff and poor staffing levels affect how safe patients feel (Sinclair, 2019). Kenward et al. (2017) noted that having information presented in an accessible way, having staff present on the wards, and patients being taken seriously by healthcare professionals also helps people feel safe in hospital.

A study was conducted by Cogley et al. (2021) about how people with SCI want information after their injury when in a general hospital. A gap in the research appeared to be, what are patients’ perceptions of safety within the acute phase of hospitalisation, following spinal cord injury?

## **How the research was conducted**

### **Who took part?**

* Eight individuals who experienced hospitalisation due to spinal cord injury were interviewed
* The average age of the participants was 64 (52 – 80 years age range)
* Two female and six male participantstook part

To be able to take part, someone needed to be in the rehabilitation phase of hospital, be over 18 years old, have a fluent level of written and spoken English, and be known to the psychology team in the ward.

### **How were people asked to take part?**

Participants were approached by a member of the research team based in the hospital, and given information about the study. If someone was interested in taking part in the research, an interview time was arranged, and they were asked for verbal and written consent to take part. If someone was unable sign for themselves, an independent witness joined.

### **What happened?**

We asked people about their experiences of safety and what affected this when they were in an acute hospital. The research took place in an NHS rehabilitation centre for spinal cord injuries in the Midlands.

The interviews were semi-structured; there were points to be covered but the discussion was encouraged to be open.

Interviews lasted on average 41 minutes and were audio recorded. Recordings were deleted after transcription, and anything that could identify the people who took part was anonymised.

The interview data was analysed using Reflexive Thematic Analysis (Braun & Clarke, 2022). This involved knowing the data thoroughly and considering the themes within and between the data.

## **What were the findings of the study?**

The study found four main themes in the data and ten sub-themes.

The themes are demonstrated through participant quotes below.

### **Theme 1: Staff attributes and interactions**

This described the impact that staff within the ward had on feelings of safety for the participants.

*Being treated as a human*

The staff being invested in the patient as an individual helped them to feel reassured to continue to make progress.

“They were visibly pleased that we were making progress. Yeah. And it's, in terms of psychological reassurance for a person in a fairly dire situation, that's, I think, really important.” (Ken)

Qualities in healthcare professionals such as treating others with dignity and respect, as well as being diligent and organised were appreciated by patients.

“All the hospital, all the nurses, all the doctors. Even my consultant. They were very, very good. Treated me with dignity and respect.” (Sheila)

*Feeling dismissed*

Hostile reactions to requests for help meant that some patients delayed asking for help at times.

“Because when you can't move, you need realigning, and they did come around and realign you, but you know, sometimes you're not in the right position and you’re uncomfortable... so you have to call them again because something’s moved or something. And there’s just no way, it’s so painful that they have to come back and they don't...So sometimes I used to just, and not just me, a lot of people used to just lie there and just be uncomfortable.” (David)

Staff talking to other colleagues without acknowledging the impact on the patient resulted in patients feeling disgusted.

“I had an experience when someone was feeding me, and their superior walked past and asked them [how] long they're going to be. Which I was disgusted with” (Steve).

*Staff knowledge*

Staff assuming a position of authority and dismissing concerns raised was challenging, distressing and unhelpful for patients.

“She goes, she said, ‘Just go to sleep. I've been a nurse for 27 years’. She says ‘I know what I'm doing” (David).

However, experience and knowledge of staff could be a positive thing that helped people feel safer.

*Information sharing*

“But because the nurses here see people go through the system so much, they’re as close to understanding as they’re ever going to be without physically going through it.” (Steve)

Participants found it helpful when staff took the time to explain procedures.

“Before I had the operation they tell you, they say to you what can happen, so this is what can happen. They explain.” (Philip)

Staff taking the time to explain reduced worry for individuals.

“You know, they, they half tell you something, or they do want you to do something, the ward staff, without explaining why. I like to know what's going on, and that kind of made me feel a bit insecure and quite cross.” (Ken)

### **Theme 2: Perceptions of self and autonomy**

This theme included how participants felt about themselves when in hospital, and how choice and control of the situation affected how safe they felt.

*Sense of self as an individual*

Feeling like themselves and being treated as an individual helped participants feel safe.

‘I’ve always been very well presented and I don’t want that to stop in hospital. People around you that want to help keep your standards. That helps you feel safe as well.’ (Steve).

Being involved in their own care and achieving goals was something that helped the participants feel safer.

“But when I do achieve a little baby something, it's very cheering” (Janet)

*Autonomy*

Adjusting to the impact of the injury and having a lack of choices around everyday options affected mood.

“I’ve lost my choices. How much do I have, how much food I put into my mouth now, I’ve lost that choice.” (Steve).

### **Theme 3: Impact of others on the ward**

This included other people present on the ward such as family/visitors and other patients.

*Sharing space with unknown others*

Having others around in similar situations could provide a sense of extra help if needed.

“And you either shout, or yell, or hope one of the other patients in the ward is awake so they can press their button” (Ken)

Sharing a space with others not of your choosing can be difficult, with one participant recalling an upsetting encounter with another patient:

“Do you think you'll ever walk again? And it really dawned on me. No, I very probably will never walk again. So then I cried a bit. How tactless can someone get?” (Janet).

One participant also witnessed abuse to staff members from other patients, which potentially affected their psychological safety.

“Verbal abuse, physical abuse. If they could catch a nurse within range. They either give her a punch or a kick. Absolutely awful.” (Ken)

*Involvement of family/visitors*

Having family and friends visiting enabled them to be involved with care, and having unrestricted visiting times helped provide some much-needed social interaction and stimulation when people were on bedrest.

“I mean, quite regular visitors were allowed in as there was no restrictions on really on visitors to speak of. So they were just allowed to come in anytime they wanted. So that was good.” (Frank)

### **Theme 4: Availability of resources**

“My physio was there and they’d be watching her, so that on the days they didn’t come, she could do the physio. Well, certain parts. She could massage my hands.” (Luke)

This included what was within the hospital and resources that the hospital has.

*Impact of physical environment*

Lack of choice around hospital routines was challenging for some individuals.

“You didn’t have a say, they put you into bed... So yeah, yeah, made you feel like a child.” (David).

Having access to correct equipment was important, and when this wasn’t available, this negatively impacted feelings of safety.

“And I couldn't press a button and I asked for a softer one and they couldn’t find one. So I had to shout out in the night” (David).

*Staffing levels*

Patients were aware of lack of staff and this impacted feelings of safety.

One participant noted the impact of the business model of the NHS, which resulted in them feeling like they were dehumanised.

“So we've just become a KPI [key performance indicator]. The whole process. We're not humans anymore” (Steve).

“Staffing levels were bad, nowhere near enough staff.” (Frank).

## **What does this all mean?**

Being in hospital following an SCI is a stressful, difficult time for individuals. Feeling psychologically safe can help people to get the best outcomes out of being in hospital.

We know from previous research that staff qualities can impact patients’ wellbeing, with irritated or superior staff provoking feelings of anger or fear in their patients (Partridge, 1994), and this was reflected in some of the experiences shared in this study. Having information shared in a timely and accessible manner was also important for the participants within this study, similar to Cogley et al’s study (2021).

Having to adjust to depending on others is difficult and can affect perceptions of how someone sees themselves (Kaiser & Kennedy, 2011). For a participant in this study, retaining a sense of self by taking care of their physical appearance was important, and helped them feel like themselves. When there is a lack of choice and autonomy in hospital due to routines and care, helping people to keep a sense of feeling like themselves is important.

The environment and resources play a key part in helping people feel safe. As bedrest is a common experience for individuals with SCI, the lack of stimulation was difficult for participants and led to increased worry and anxiety. Family and friends being allowed unrestricted visiting was helpful for patients within this study, and previous research suggested that having unrestricted visiting can improve patient satisfaction with care (Smith et al., 2009). Having family and friends present to hear information and be involved with aspects of care, helps individuals feel safer as they can discuss information with others (Cogley et al., 2021).

## **What steps need to be taken?**

Some suggestions for future clinical practice include:

* Trauma-informed spaces and care, for example, with patient choice over whether to choose shared bays or not (Petrillo, 2021), and with more stimulation when on bedrest (i.e., accessible televisions and socialising opportunities)
* Training/increased awareness on the psychological impact of SCI for hospital staff. This could include messages such as the importance of every interaction, taking time to connect human-human rather than patient-caregiver, and being aware of the isolation many experience.
* Management of current pressures, for example, improving staffing levels. Within the current climate, this may not be possible, but making sure that staff pressures do not transfer to patient interactions would help promote feelings of safety and being cared for.

## **Future research**

Future research could include a case series of patients’ journeys; one participant noted that they felt in a different headspace as time progressed, and capturing this change within research could help further understanding of how people with spinal cord injury (or patients in need of any long-term care) experience safety within hospital.

## **Key points**

**References**

* Things that can affect how safe someone feels in hospital after a SCI include:
* **Staff and their interactions:** staff who were kind, respectful, diligent and took time to connect with people on a human level helped patients feel safe, as did those with expert knowledge and who shared information accessibly. Rude and abrupt staff made patients feel less safe and caused them to minimise needs.
* **Perceptions of self and autonomy:** having choices in situations where possible helped people feel safer, as did being treated as an individual and seeing achievements. Nights at hospital and the situation being unfamiliar made people feel less safe.
* **Impact of others in the ward:** visitors help patients feel safer, and other patients on the ward may have a negative or positive impact on feelings of safety.
* **Availability of resources:** positive reputations of hospital and the NHS helped people feel safer, as did access to equipment and other safety measures.
* **Suggestions for the future include training for staff, management of staff pressures and trauma-informed hospital design**

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# **Appendices**

Appendix 1: Author guidelines for BJHP

Appendix 2: CASP Qualitative Tool Checklist Questions and checklist for studies included

Appendix 3: Author guidelines for Spinal Cord

Appendix 4: Reflective log extracts

Appendix 5: IPR approval

Appendix 6: REC approval

Appendix 7: HRA approval

Appendix 8: Approval ‘Green light’ from research site

Appendix 9: Semi-structured interview schedule

Appendix 10: Information sheet

Appendix 11: Blank consent form

Appendix 12: Debrief form

Appendix 13: Previous working theme map

Appendix 14: Data extract to demonstrate analysis

Appendix 15: Table of themes and example quotations

**Appendix 1:**

Author guidelines for submission to British Journal of Health Psychology for the literature review.

[British Journal of Health Psychology: Author Guidelines (wiley.com)](https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448287/homepage/forauthors.html)

**Appendix 2:**

Critical Appraisal Skills Programme Qualitative Tool Checklist Questions (CASP, 2018) and checklist for studies included:

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

*CASP Tool Checklist (Appendix 2) Answers for Studies Included* †

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Authors, year and country | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 | Q9 | Q10 |
| Barkensjo et al. (2018)  Sweden | Y | Y | Y | N | N | C | Y | N | Y | Y |
| Browall et al. (2013)  Sweden | Y | Y | Y | N | Y | Y | Y | Y | Y | Y |
| Hassel et al. (2016)  Sweden | Y | Y | N | Y | C | Y | N | C | Y | Y |
| Heine et al. (2004)  Australia | Y | Y | Y | C | Y | Y | N | Y | Y | Y |
| Hupcey (2000)  USA | Y | Y | C | Y | Y | N | C | Y | Y | Y |
| Komatsu et al. (2016)  Japan | Y | Y | Y | Y | Y | N | C | Y | Y | Y |
| Larkin et al. (2012)  Ireland | Y | Y | Y | Y | Y | Y | C | Y | Y | Y |
| Lasiter (2011)  USA | Y | Y | Y | Y | C | Y | Y | C | C | Y |
| Lyndon et al. (2018)  USA | Y | Y | Y | C | Y | N | Y | Y | Y | Y |
| New et al. (2019)  Canada | Y | Y | Y | Y | Y | N | Y | Y | Y | Y |
| Worster & Holmes (2009)  UK | Y | Y | Y | Y | Y | C | Y | Y | C | Y |

† In-line with CASP checklist wordings, the following key was used: Y – Yes, C – Can’t Tell, N - No

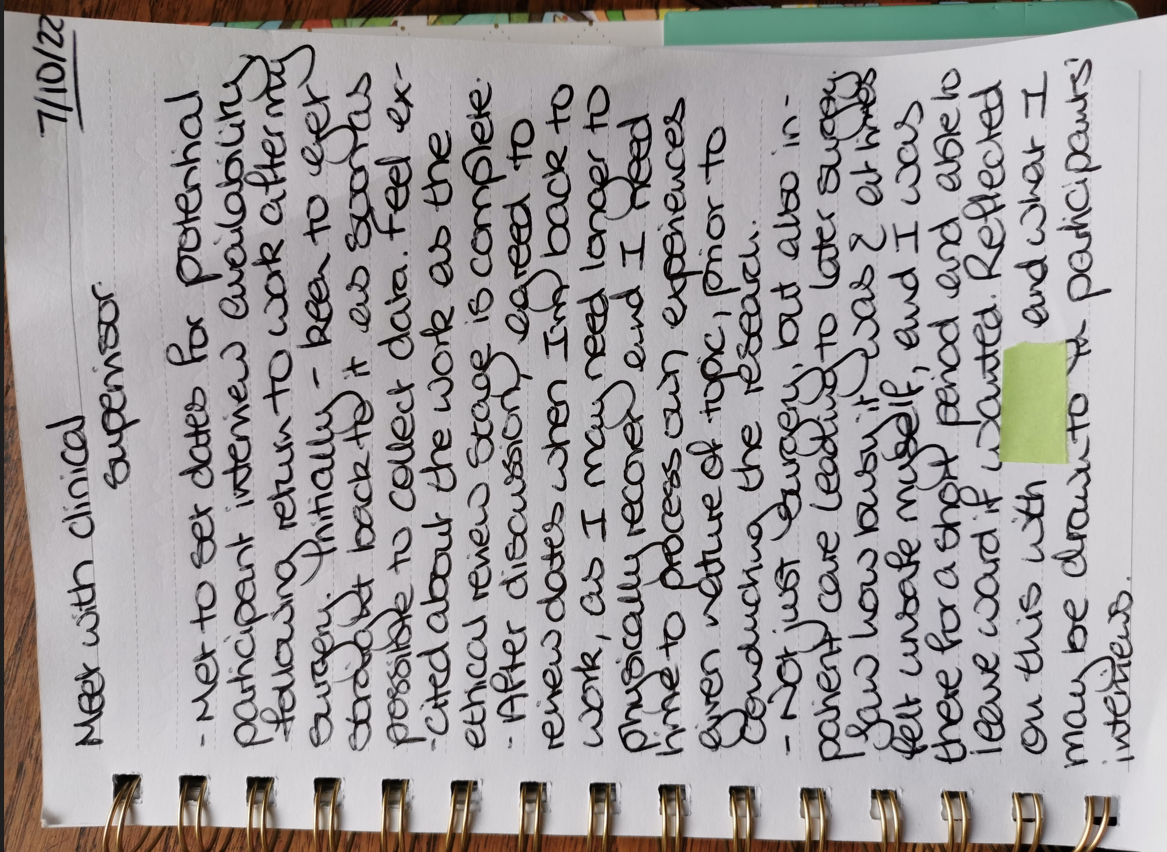
**Appendix 3:**

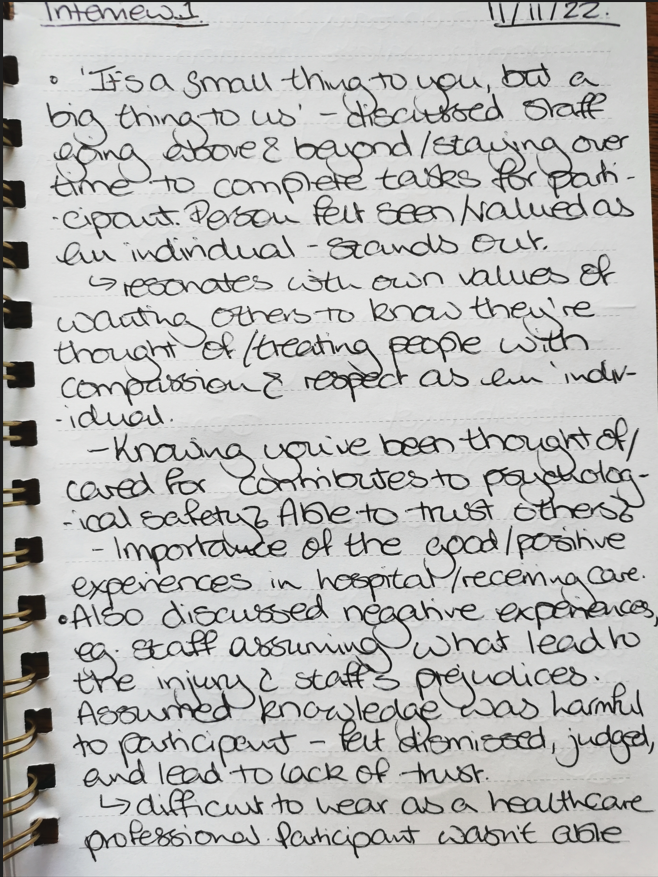
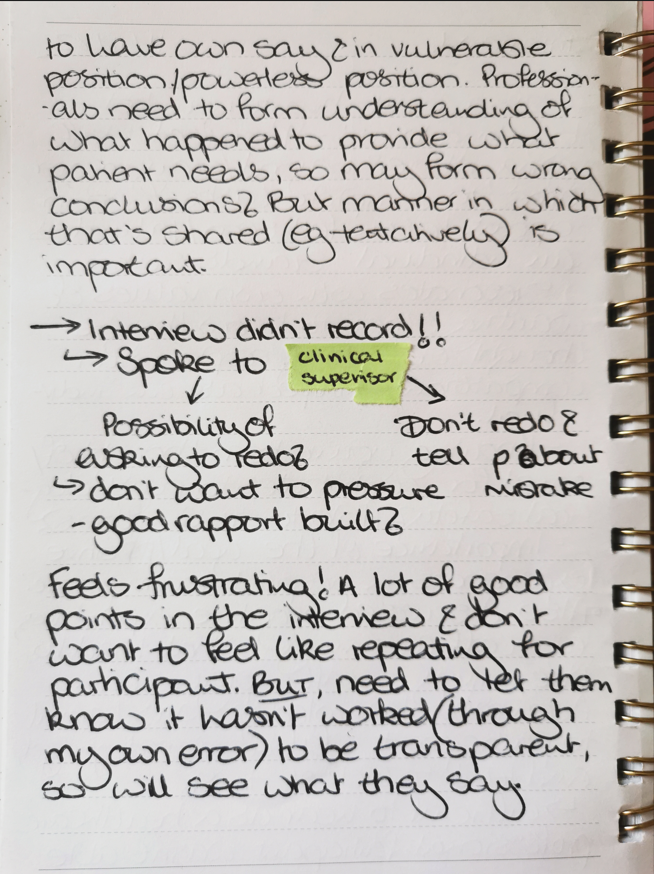
Author guidelines for Spinal Cord, for submission for the empirical paper.

[Guide to Authors (nature.com)](https://www.nature.com/documents/sc-gta.pdf)

**Appendix 4:**

Reflective log extracts

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**Appendix 5:**

Staffordshire University Independent Peer Review (IPR) approval letter



**INDEPENDENT PEER REVIEW APPROVAL FEEDBACK**

|  |  |
| --- | --- |
| **Researcher Name** | Lynne Rothwell |
| **Title of Study** | Patients’ perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury |
| **Status of approval:** | **Approved** |

Thank you for your resubmission to the Independent Peer Review (IPR) Panel. Your application is now approved

**Action now needed:**

You must now apply to the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without this second approval. Please note that the university sponsor to be named on the form is Dr Tim Horne.

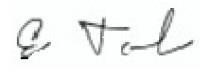
Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received approval you can commence your study.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

When your study is complete, please send an end of study report to Edward Tolhurst: e.tolhurst@staffs.ac.uk. A template can be found on the ethics Blackboard site.

**Comments for your consideration: None**



**Signed**:Dr Edward Tolhurst Date: 28th March 2022

` University IPR coordinator

**Appendix 6:**

REC review approval letter

Lothian NHS Board **South East Scotland Research**

**Ethics Committee 01**

2nd Floor, Waverley Gate

2-4 Waterloo Place

Edinburgh

EH1 3EG

Telephone 0131 536 9000 [www.hra.nhs.uk](http://www.hra.nhs.uk/)

|  |
| --- |
| **Please note: This is the favourable**  **opinion of the REC only and does**  **not allow you to start your study at NHS sites in England until you receive HRA Approval** |

Enquiries to: Sandra Wyllie

Mobile: 07814 764241

Email: sandra.wyllie@nhslothian.scot.nhs.uk

|  |  |
| --- | --- |
| 02 August 2022    Ms Lynne Rothwell  Dear Ms Rothwell, |  |
| **Study title:** | **Patients’ perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury** |
| **REC reference:** | **22/SS/0047** |
| **Protocol number:** | **SU\_21\_062** |
| **IRAS project ID:** | **314884** |

Thank you for your letter of 29th July 2022 responding to the Research Ethics Committee’s (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Good practice principles and responsibilities**

The [UK Policy Framework for Health and Social Care Research](https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/) sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of [research transparency:](https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/research-transparency/)

1. [registering research studies](https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/research-transparency/registering-research-studies/)



1. [reporting results](https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/research-transparency/making-results-public/)
2. [informing participants](https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/research-transparency/informing-participants/)
3. [sharing study data and tissue](https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/research-transparency/making-data-and-tissue-accessible/)

**Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose,

‘clinical trials’ are defined as:

* clinical trial of an investigational medicinal product
* clinical investigation or other study of a medical device
* combined trial of an investigational medicinal product and an investigational medical device
* other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: [Research registration and research project identifiers)](https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: [https://www.hra.nhs.uk/planning-and-improving-research/applicationhttps://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/summaries/research-summaries/](https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/)

**N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months**.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven’t already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at:

<https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/>

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**After ethical review: Reporting requirements**

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

* Notifying substantial amendments
* Adding new sites and investigators
* Notification of serious breaches of the protocol
* Progress and safety reports
* Notifying the end of the study, including early termination of the study
* Final report
* Reporting results

The latest guidance on these topics can be found at [https://www.hra.nhs.uk/approvalshttps://www.hra.nhs.uk/approvals-amendments/managing-your-approval/amendments/managing-your-approval/.](https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/)

**Ethical review of research sites**

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

|  |  |  |
| --- | --- | --- |
| *Document* | *Version* | *Date* |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance] |  | 20 May 2022 |
| Interview schedules or topic guides for participants [Interview schedule] | 1 | 10 June 2022 |
| IRAS Application Form [IRAS\_Form\_14062022] |  | 14 June 2022 |
| Letter from sponsor [Sponsor letter] |  | 10 June 2022 |
| Other [IPR ] | 1 | 16 June 2022 |
| Other [IPR amendment letter] | 1 | 16 June 2022 |
| Other [Debrief sheet] | 1.1 | 25 July 2022 |
| Other [REC reply letter with amendment table] | 1.0 | 29 July 2022 |
| Other [Debrief sheet Tracked] | 1.1 | 25 July 2022 |
| Participant consent form [consent form] | 1.1 | 25 July 2022 |
| Participant consent form [consent form Tracked] | 1.1 | 25 July 2022 |
| Participant information sheet (PIS) [PIS] | 1.1 | 25 July 2022 |
| Participant information sheet (PIS) [PIS Tracked] | 1.1 | 25 July 2022 |
| Research protocol or project proposal [Protocol] | 1.1 | 25 July 2022 |
| Research protocol or project proposal [Protocol Tracked] | v1.1 | 25 July 2022 |
| Summary CV for Chief Investigator (CI) [CV] |  | 25 May 2022 |
| Summary CV for student [CV] |  | 10 June 2022 |
| Summary CV for supervisor (student research) [KG CV] |  | 10 June 2022 |
| Summary of any applicable exclusions to sponsor insurance (nonNHS sponsors only) [Insurance] | 1 | 20 May 2022 |

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/> **HRA Learning**

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: [https://www.hra.nhs.uk/planning-and-improvinghttps://www.hra.nhs.uk/planning-and-improving-research/learning/research/learning/](https://www.hra.nhs.uk/planning-and-improving-research/learning/)

**IRAS project ID: 314884 Please quote this number on all correspondence**

With the Committee’s best wishes for the success of this project.

Yours sincerely



Dr Lucy Kershaw Chair

Email:sandra.wyllie@nhslothian.scot.nhs.uk

*Enclosures:*  “After ethical review – guidance for

researchers” *[SL-AR2]*

*Copy to:* Dr Tim Horne

*Lead Nation*

England: approvals@hra.nhs.uk

**Appendix 7:**

Copy of HRA approval letter

|  |  |
| --- | --- |
|  | Email: approvals@hra.nhs.uk HCRW.approvals@wales.nhs.uk |



Ms Lyne Rothwell

03 August 2022

Dear Ms Rothwell

**HRA and Health and Care**

**Research Wales (HCRW)**  **Approval Letter**

|  |  |
| --- | --- |
| **Study title:** | **Patients’ perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury** |
| **IRAS project ID:** | **314884** |
| **Protocol number:** | **SU\_21\_062** |
| **REC reference:** | **22/SS/0047** |
| **Sponsor** | **Staffordshire University** |

I am pleased to confirm that [**HRA and Health and Care Research Wales (HCRW) Approval**](https://www.myresearchproject.org.uk/help/hlphraapproval.aspx) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the “Information to support study set up” section towards the end of this letter.

**How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?**

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](https://www.myresearchproject.org.uk/help/hlpnhshscr.aspx) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

**How should I work with participating non-NHS organisations?**

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](https://www.myresearchproject.org.uk/help/hlpsitespecific.aspx#non-NHS-SSI) in accordance with their procedures.

**What are my notification responsibilities during the study?**

The standard conditions document “[*After Ethical Review – guidance for sponsors and investigators*”](https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/research-ethics-committee-review/applying-research-ethics-committee/), issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

* Registration of research
* Notifying amendments
* Notifying the end of the study

The [HRA website](https://www.hra.nhs.uk/) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

**Who should I contact for further information?**

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **314884**.Please quote this on all correspondence.

Yours sincerely,

Natalie Wilson

Approvals Manager

Email: approvals@hra.nhs.uk

*Copy to: Dr Tim Horne, Sponsor contact* **List of Documents**

The final document set assessed and approved by HRA and HCRW Approval is listed below.

|  |  |  |
| --- | --- | --- |
| *Document* | *Version* | *Date* |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance] |  | 20 May 2022 |
| Interview schedules or topic guides for participants [Interview schedule] | 1 | 10 June 2022 |
| IRAS Application Form [IRAS\_Form\_14062022] |  | 14 June 2022 |
| Letter from sponsor [Sponsor letter] |  | 10 June 2022 |
| Other [IPR ] | 1 | 16 June 2022 |
| Other [IPR amendment letter] | 1 | 16 June 2022 |
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| Participant consent form [consent form] | 1.1 | 25 July 2022 |
| Participant information sheet (PIS) [PIS Tracked] | 1.1 | 25 July 2022 |
| Participant information sheet (PIS) [PIS] | 1.1 | 25 July 2022 |
| Research protocol or project proposal [Protocol] | 1.1 | 25 July 2022 |
| Research protocol or project proposal [Protocol Tracked] | v1.1 | 25 July 2022 |
| Summary CV for Chief Investigator (CI) [CV] |  | 25 May 2022 |
| Summary CV for student [CV] |  | 10 June 2022 |
| Summary CV for supervisor (student research) [KG CV] |  | 10 June 2022 |
| Summary of any applicable exclusions to sponsor insurance (nonNHS sponsors only) [Insurance] | 1 | 20 May 2022 |

**Information to support study set up**

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

|  |  |
| --- | --- |
| **IRAS project ID** | **314884** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Types of participating**  **NHS**  **organisation** | **Expectations related to confirmation of capacity and capability** | **Agreement to be used** | **Funding arrangements** | **Oversight expectations** | **HR Good Practice Resource Pack expectations** |
| Research  activities and procedures as per the protocol and other study documents will take place at  participating  NHS  organisations. | Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed. | The single  participating  NHS  organisation has confirmed that no Organisation Information  Document is  required in this instance. | No Organisation  Information Document is required so relevant conversations should be held between the research team and the relevant R&D office to understand study funding arrangements. | In line with  HRA/HCRW  expectations a Local Collaborator should be appointed at  participating  NHS  organisations of this type. | Where an external individual will be conducting any of the research activities that will be undertaken at this site type then they would be expected to hold a Letter of Access. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm Occupational Health Clearance. These should confirm standard DBS checks. |

**Other information to aid study set-up and delivery**

|  |
| --- |
| *This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.* |
| The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio |

**Appendix 8:**

‘Green light’ letter from research site

**Confirmation of Green Light**

|  |  |
| --- | --- |
| **Title:** | **Patient Perceptions of Psychological Safety** |
| **R&D / CLRN Reference:** | **RL1 846** |

|  |  |
| --- | --- |
| **Action** | **Date completed** |
| Site Initiation Visit has been completed and any  issues raised have been resolved | N/A |
| Support Services e.g. pharmacy, radiography  have confirmed readiness | N/A |
| Study drug, IMP or study devices have been  received | N/A |
| Randomisation system is in place | N/A |
| GCP training has been completed as necessary | Yes – on EDGE |
| Delegation Log has been completed | 05/10/2022 |
| Trial Master File and or Investigator Site File  has been set-up | 05/10/2022 |
| Unblinding procedures are in place | N/A |
| Confirmation of agreement of source data/documents | Source data is interview transcripts (confidential to research team only) |
| Other: |  |

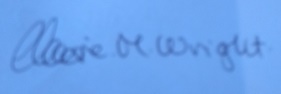
Please return to the Research Office once all the above have been completed (if applicable). Once received, the Research Office will confirm “Green Light” which will then and only then, allow you to start recruiting to your study. ***Please do not start recruiting to your study until you have this Confirmation of Green Light document signed by the R&D office.***

Investigator / Study Co-ordinator signature:……LARothwell…………………………………………….

Date:…6/10/22………………………………………..

**Green Light confirmed:**

R&D office Name:…………Claire Wright…………………………………………………….

R&D office Signature:……………… …………………………………………

Date:…………………06/10/2021…………………………………………………….

**Appendix 9:**

Semi-structured interview schedule

**Version: 1.1**

**Date: 25/7/22**

**Preliminary Interview Schedule**

To be read to participants following consent given and prior to interview:

This study is looking into people’s perceptions of safety whilst in the acute phase of being in hospital. In this study, acute phase is immediately after and prior to rehabilitation. As you’ve experienced this, we’d be really interested to know how the experience was. This interview is semi-structured, which means that there are some questions and points that I’d like to cover, however we may cover them naturally as we’re talking. Please let me know if you would like a break at any point, and as we discussed within the information sheet and consent form, if you would like to stop or withdraw your participation, you have a right to do that and there will be no penalties for this.

Initial questions/prompt questions:

* Thinking back to when you were first in hospital, what was that like? What were the first things you remember from this time?
* Were there any times you felt safe in hospital? Can you identify what it was that made you feel that way? What did it feel like to be safe?
* Were there any times you felt unsafe within hospital? Can you identify what it was that made you feel that way?
* What helps you feel safe generally? How would you define safety?
* How did you cope with feeling unsafe?

Points to consider:

* Physical environment
* Autonomy
* Communication
* Support

**Appendix 10:**

Participant information sheet

**Version: 1.1**

**Date: 25/7/22**

**INFORMATION SHEET FOR PARTICIPANTS**

*Project Reference Number: SU\_21\_062*

*IRAS Project ID: 314884*

**Title of study**

Patient’s perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury

**Invitation**

I would like to invite you to participate in this research project which forms part of my doctoral research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

**What is the purpose of the study?**

To gain understanding of your perceptions of psychological safety whilst staying on a rehabilitation ward for spinal cord injury. This includes what makes you feel safe within your environment, with others and within ourselves, and this information could help to guide practice in the future.

**Why have I been invited to take part?**

As a current patient in the Midland Centre for Spinal Injuries rehabilitation ward, we would like to know your perceptions of what makes you feel safe.

**What will happen if I take part?**

You will be invited to arrange a suitable interview time with myself, which will take place in a confidential setting (such as a therapy room) within the hospital. You will be given a consent form to read through and sign prior to the interview.

You’ll be asked a series of open questions that explore what your perceptions and experience of psychological safety has been. This may include questions such as ‘What makes you feel safe within the rehabilitation ward?’. The interview will take approximately an hour, and you are welcome to ask for and take a break whenever you want to.

The interview will be recorded (audio only), so it can be transcribed later. This will all take place after you have consented, and are happy to continue. I will let you know when the interview is being recorded and when it is stopped.

The interview, when transcribed, will be analysed by myself. All personal information will be anonymised, and all data (the interviews) will be stored on secure, NHS computers, and encrypted as well as password protected.

The content of the interview will not be recorded in any medical notes and remains separate to the care provided by the hospital. The interview will be confidential, with the exception of if there is a disclosure regarding risk to self or others. In the event of this, appropriate staff members will be informed, and this will be discussed in the moment.

**Do I have to take part?**

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact myself, or a member of the research team, if you have any questions that will help you make a decision about taking part. If you decide to take part we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

**What are the possible risks of taking part?**

We’re aware that talking about what makes us feel safe can be difficult and emotive. During the interview, difficult emotions may arise. The interview can be stopped, paused or terminated at any point, with no repercussions. There is support available on site through the psychology team, should you wish to discuss anything further, which can be accessed through contacting the team. A check-in with the psychology team following the interview will be offered, and a debriefing sheet with further support information will be provided at the end of the interview.

**What are the possible benefits of taking part?**

There are not expected to be any direct individual benefits for participating. However, you may learn more about how you think about safety and rehabilitation.

**Data handling and confidentiality**

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

The data controller for this project will be Staffordshire University. The university will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the GDPR is a ‘task in the public interest’. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner’s Office, please visit [*www.ico.org.uk*](http://www.ico.org.uk/).

Any personal identifying information will be anonymised, and the content of the anonymised interview transcripts will be kept confidential and only accessible to the research team. Audio recording of the interview will be stored on a secure, encrypted NHS laptop this is password protected.

Only the research team will have access to the data (the interview transcript) that you provide. The research data is kept for 10 years, inline with university policy. Your consent form, containing your personal information, will be destroyed after 3 months of the study end in September 2023.

The details for the research team are at the bottom of this sheet.

**Data Protection Statement**

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal anonymised data for research purposes under the data protection law is a ‘task in the public interest’ You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

**Ethics**

This study has been reviewed by the NHS Health Research Authority, and has received a favourable review (reviewed by SESREC01).

**How will the information be used?**

We will need to use information from you in this research project. If you are unsure about your level or completeness of injury, we may ask to get this information from your medical records at the hospital.

This information will include your name, gender, age, level and completeness of injury and time since injury.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

People will use this information to help make sense of the data from the interviews and understand if there are any patterns.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

**What if I change my mind about taking part?**

You are free withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up untilSeptember 2022,after which withdrawal of your data will no longer be possible due to the data being processed and unable to be extracted.

If you choose to withdraw from the study we will not retain any information that you have provided us as a part of this study.

**Where can I find out more about how my information is used?**

You can find out more about how we use your information:

* at [www.hra.nhs.uk/information-about-patients/](https://www.hra.nhs.uk/information-about-patients/)
* by asking one of the research team directly or
* by sending an email to the research team

**What will happen to the results of the study?**

The study will be submitted as part of the work required to gain the Doctorate. It will be submitted to a peer reviewed journal to contribute to the body of work in the field.

**Who should I contact for further information?**

If you have any questions or require more information about this study, please contact me, or a member of the research team, using the following contact details:

Lynne Rothwell

Lynne.rothwell@student.staffs.ac.uk

Dr Sally Kaiser

[Sally.kaiser@nhs.net](mailto:Sally.kaiser@nhs.net)

Dr Kim Gordon

[Kim.gordon@staffs.ac.uk](mailto:Kim.gordon@staffs.ac.uk)

**What if I have further questions, or if something goes wrong?** 

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

Dr Tim Horne

[ethics@staffs.ac.uk](mailto:ethics@staffs.ac.uk).

**Thank you for reading this information sheet and for considering taking part in this research.**

**Appendix 11:**

Blank consent form

Version: 1.1

Date: 25/7/22

IRAS ID: 314884

Centre Number:

Study Number:

Participant Identification Number for this trial:

**CONSENT FORM**

Title of Project: Patient’s perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury

Name of Researcher: Lynne Rothwell

**Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR). This is detailed further within the Participant Information Sheet provided.**

Please initial box

1. I confirm that I have read the information sheet dated 25/7/22 (version 1.1) for the  
   above study. I have had the opportunity to consider the information, ask questions and have  
   had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time  
   without giving any reason, without my medical care or legal rights being affected.
3. I agree to my consultant being informed of my participation in the  
   study, including any necessary exchange of information about me between my consultant and the research team.
4. I understand that my information will be anonymised and kept securely, and that my answers within the research will be kept confidential. I understand that the exception to confidentiality would be any disclosure of information that suggests severe risk to myself or to others.



1. I consent to the interview being audio recorded and transcribed, in order for the data to be analysed. I understand that the primary researcher will be transcribing and analysing this.
2. I consent to demographic information being collected, such as my gender, age (within a range), level and completeness of injury, and time since injury. I understand that these details will be anonymised.



1. If I am unable to provide level and completeness of injury or time since injury information, I consent to my hospital records being consulted for this information.
2. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person seeking consent Date Signature

1 copy each to the principal researcher, participant and participant’s notes within the hospital

**Appendix 12:**

Debrief form

**Version: 1.1**

**Date: 25/7/22**

**Debrief sheet**

**Study title: Patient’s perceptions of psychological safety within the acute phase of hospitalisation following a spinal cord injury**

Thank you for taking part in the interview. Here is some information on what will happen next, and where you may be able to seek support, should you feel you require it after participating.

**What will happen to my information?**

The interview, when transcribed, will be analysed by myself. All personal information will be anonymised, and all data (the interviews) will be stored on secure, NHS computers, and encrypted as well as password protected.

The information will then be written up in a paper, and submitted to the university as part of a doctoral degree. It will also be submitted to scientific journals for review by peers in the field.

**Why is this research taking place?**

There doesn’t appear to be any research completed on patients’ perceptions of safety in hospital following a spinal cord injury (SCI). Without this research, we’re unsure what contributes to people feeling safe or unsafe within an acute hospital setting following SCI. This research has the potential to improve knowledge and awareness of what contributes to psychological safety in SCI settings, and this could in theory improve practice in the future.

**I no longer wish for my information to be used. What can I do?**

You are free to withdraw your information without reason. Withdrawing your consent for your information to be used will not affect you and your care in any way.

You are able to withdraw your data from the study up untilSeptember 2022,after which withdrawal of your data will no longer be possible due to the data being processed and unable to be extracted.

If you choose to withdraw from the study we will not retain any information that you have provided us as a part of this study. Please contact a member of the research team to discuss withdrawing your consent to use your information.

**Further support**

If you feel like you need further support for any issues raised during the interview, please contact the research team (details below). If you do not feel able to do this, here are some useful contacts:

***NHS services:***

*Within the hospital*

**Clinical Psychology team at MCSI*:***

01691 404649

Alternatively, a member of the ward staff will contact the team to see you.

*Mental health support available after discharge from MCSI\**

**Shropshire IAPT**

https://shropshireiapt.mpft.nhs.uk/

0300 123 6020

**Birmingham Health Minds**

www.bsmhft.nhs.uk/our-services/birmingham-healthy-minds/

0121 301 2525

\*Please note, services will vary depending on location. Please ask a member of the psychology team for details of available services in your local area, should you require further support after discharge.

***Charities:***

**Spinal Injury Association**

[www.spinal.co.uk](http://www.spinal.co.uk)

0800 980 0501

**Back Up Trust**

[www.backuptrust.org.uk](http://www.backuptrust.org.uk)

020 8875 1805

**Aspire**

[www.aspire.org.uk](http://www.aspire.org.uk)

020 8954 5759

Thank you for taking part in the research. If you have any further questions, please contact a member of the research team:

Lynne Rothwell (Principal Investigator)

[Lynne.rothwell@student.staffs.ac.uk](mailto:Lynne.rothwell@student.staffs.ac.uk)

Dr Sally Kaiser (Clinical Supervisor)

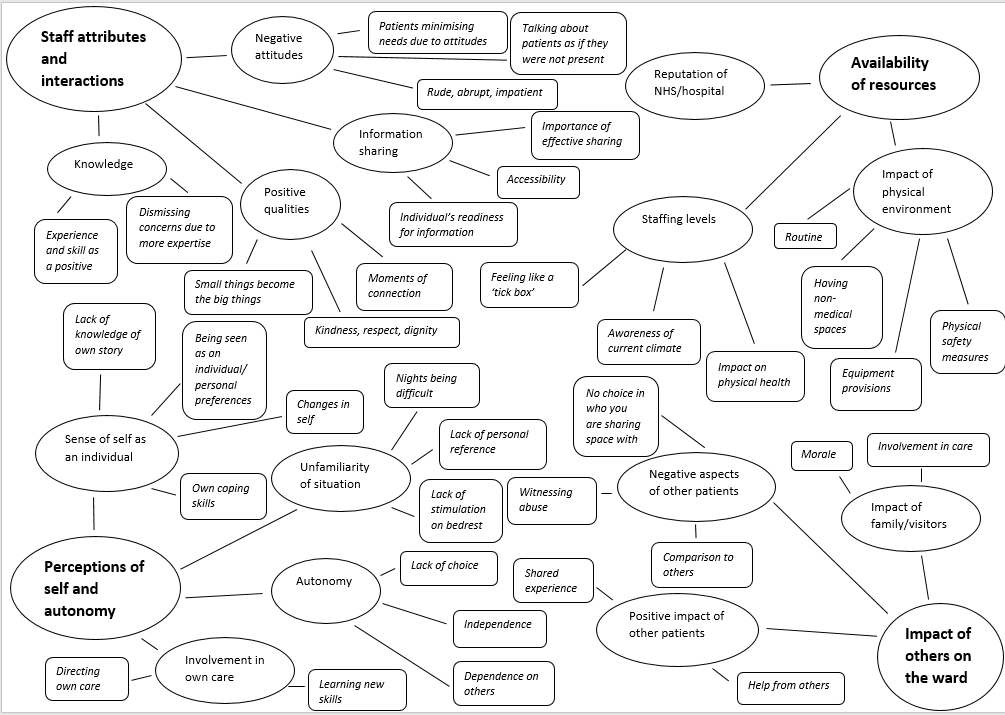
[Sally.kaiser@nhs.net](mailto:Sally.kaiser@nhs.net)

Dr Kim Gordon (Academic Supervisor)

[Kim.gordon@staffs.ac.uk](mailto:Kim.gordon@staffs.ac.uk)

**Appendix 13:**

Previous working theme map



**Appendix 14:**

Data extract to demonstrate analysis process

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Speaker** | **Transcript extract** | **Coding** | **Initial theme** | **Sub-theme** | **Theme** |
| Ken | And I did six weeks go completely flat on my back bedrest. So all I could see of the world is, you can't see faces, people come and sit down next to you and talk to you. You can't see faces. You can't recognise people unless they're right over your head. Which was difficult because they're the people looking after you. I was completely dependent on the ward staff. And I was on what they call a log roll, where you can't be call a flat on your back. You have to be rolled. Check for pressure sores, all the rest of it. And that you know, every so many hours. Your only means of contact with anybody when you're laying there is the alarm. | Unable to see or recognise faces unless over you.  Being dependent on ward staff  Physical health checks  Alarm being the only means of contact | Lack of stimulation on bedrest  Dependence on others  Equipment provisions | Unfamiliarity of situation  Autonomy  Staff knowledge  Impact of physical environment | Perceptions of self and autonomy  Perceptions of self and autonomy  Staff attributes and interactions  Availability of resources |
| PI: | Yeah. |  |  |  |  |
| Ken: | But there’d be occasions where they'd come and roll you, they set you back. You'd have an independent water supply. And they'd forget to put the alarm button where you could reach it. So then you're completely isolated. And you either shout, or yell, or hope one of the other patients in the ward is awake so they can press their button. The fact that you're completely dependent on other people for you know the basics, bowel movements, urination, food, hospital food. When you're laying flat on your back is obviously difficult to swallow. And it comes as a puree. My taste wasn't brilliant after the after the accident, but the hospital food just was all the same texture and all tasted the same. | Unable to call for help if buzzer not left  Isolated  Hope other patients help  Changes in taste | Equipment provisions  Help from others  Changes in self | Impact of physical environment  Sharing space with unknown others  Sense of self as an individual | Availability of resources  Impact of others on the ward  Perceptions of self and autonomy |
| PI: | Yeah. |  |  |  |  |
| Ken: | But you realise that you've got to have sustenance. I lost weight, I went stick thin within a matter of two or three weeks. They say that you lose muscle mass at 3% a day so I kind of wasted away to a stickman. I've must have lost seven or eight kilos in the first two weeks. Mainly because all I could eat was this puree and yoghurt. But you kind of, I can't speak for how other people deal with it. But I kind of put the, I'm totally dependent on these people here and it's really scary, I just put that to the back of my mind and thought well they do it every day. You just have to rely on their skill. But there are... and I got moved around a bit. They’re like a four, four bays for people to a bay in the ward. And quite often it was I mean, I'm 70 just, I was put with guys in between 85 and 95. Wow. Yeah. So the atmosphere the ward is different. Yeah, you know, some of them were good. Some of them were awful. And I was really shocked at the way they treated the staff. | Physical changes to self during hospital  Dependence on staff  Lack of choice when being moved  Witnessing abuse | Changes in self  Trusting experience and skill  No choice in who you are sharing space with  No choice in who you are sharing space with | Sense of self as an individual  Staff knowledge  Sharing space with unknown others  Sharing space with unknown others | Perceptions of self and autonomy  Staff attributes and interactions  Impact of others on the ward  Impact of others on the ward |
| PI: | The other patients, you mean? |  |  |  |  |
| Ken: | Oh yeah, awful. Yeah. Verbal abuse, physical abuse. If they could catch a nurse within range. They either give her a punch or a kick. Absolutely awful. I was quiet, I did what I was told. Mainly as a bit of an offset because the poor girls you know were dealing with difficult stuff. But in terms of in terms of if psychological effect. Yeah, crosses your mind occasionally, you're completely dependent here. But I kind of put it to the back of your mind and just got on with it. Got into the routine. Didn't to think too much about the consequences. Because I knew I was going to get well enough from the first two or three weeks. | Witnessing abuse  Dependence on others  Routines in hospital  Compartmentalising and hope | No choice in who you are sharing space with  Dependence on others  Routines  Own coping skills | Sharing space with unknown others  Autonomy  Impact of physical environment | Impact of others on the ward  Perceptions of self and autonomy  Availability of resources  Perceptions of self and autonomy |
| PI: | Yeah, when you could feel that sort of coming back a bit. |  |  |  |  |
| Ken: | Yeah. I was fortunate enough that the hospital allowed my family to come in and see me every day. And they did it for bless them, they did it for 80 days. The physio department would come around and kind of keep you from seizing up completely, various exercises, legs, arms. And they showed my family about the basics of it and he gave me three or four hours of physio every day. Yeah, bless him. So I concentrated on that because it was helping strength to come back. It's the helplessness, not only just relying on other people for the food and basic bodily functions, even when you, I was six weeks dead flat, soon as the sixth week was over, they gave me some limitations. They said right, you can't sit up but only as far as 30 degrees. Any further than that and you must wear the neck brace. | Visits from family  Family helping with exercises  Care independent of the staff team  Feeling helpless due to dependence on others | Morale  Involvement in care  Directing own care  Dependence on others | Impact of family/visitors  Impact of family/visitors  Involvement in own care  Autonomy | Impact of others on the ward  Impact of others on the ward  Perceptions of self and autonomy  Perceptions of self and autonomy |

**Appendix 15:**

Theme table and example quotes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Theme** | **Subtheme** | **Participants contributing to subtheme** | **Initial codes** | **Example quotes** |
| Staff attributes and interactions | Feeling dismissed | Steve, Luke, Janet, Frank, David, Ken | Patients minimising needs due to attitudes | *“So sometimes I used to just, and not just me, a lot of people used to just lie there and just be uncomfortable.”* (David)  *“So when I’d shout out about two o'clock in the morning ... A couple of the staff they didn't really like, they weren’t very nice about it so I used to wait sometimes until the morning which would make me feel uncomfortable”* (David). |
| Talking about patients as if they were not present | *“I had an experience when someone was feeding me, and their superior walked past and asked them long they're gonna be. Which I was disgusted with.”* (Steve)  *“[t]hey all stood around on one occasion, and consultants said looking at them all, ‘that's a thing with tetraplegics they always have to do’ or whatever and I thought, Oh, I’ve got a label on now saying tetraplegic”* (Janet). |
| Rude, abrupt, impatient | *“Some of the staff, particularly nights, were rude. They shouted at you for ringing the bell or the buzzer, they were busy, things like that, and not answering the buzzer for hours.”* (Frank)  *“They all at [first hospital] seemed to be so cross… I dreaded it if I dropped anything and if I buzzed at night, they were, I suppose they … didn't really want to be buzzed at 3:00 AM.”* (Janet). |
| Information sharing | Steve, Philip, Luke, Janet, Ken, Sheila | Importance of effective sharing | *“Yes, seconds. Yeah, seconds and it can save… but it can save the hours and days of fretting and mulling and thinking over it”* (Ken). |
| Accessibility | *“They explained things to me because I'm not, I'm not medically you know, medically I don't know anything”* (Sheila).  *“You know, they, they half tell you something, or they do want you to do something, the ward staff, without explaining why. I like to know what's going on, and that kind of made me feel a bit insecure and quite cross.”* (Ken) |
| Individual’s readiness for information | *“They didn't say they didn't tell me a lie that they're going to cure me but they reassured me that they’re going to give me all the help necessary to learn new skills.”* (Sheila)  *“Before I had the operation they tell you, they say to you what can happen, so this is what can happen. They explain.”* (Philip) |
| Being treated as a human | Steve, Philip, Luke, Janet, Frank, David, Ken, Sheila | Moments of connection | *“You might, you have a chance to talk to the people, I have to be fed. But when they’re feeding you you know you can’t actually talk. When you’re feeding you’re not saying anything. [LR: It's a bit like small talk really. Just that connection, you know, you know.] That was, that helped.”* (Philip)  *“They were visibly pleased that we were making progress. Yeah. And it's, in terms of psychological reassurance for a person in a fairly dire situation. That's, I think, really important.”* (Ken)  *“Just the fact that you can have a laugh with them. You can have a laugh and break the day up.”* (Luke) |
| Kindness, respect, dignity | *“All the hospital, all the nurses, all the doctors. Even my consultant. They were very, very good. Treated me with dignity and respect”* (Sheila).  *“I think that the, the people aspect of it. And the way that people communicate with you, is probably the single most important thing for making you feel safe.”* (Ken)  *“They were they were organised. They were diligent.”* (Ken)  *“You don’t have to worry. They do all that for you... (LR: What does that leave space for?) I think about all the stuff I want to achieve”* (Ken). |
| Small things become the big things | *“When I first came to the hospital, I had a real guilt trip about, I thought that you would only have their attention or assistance for medically derived situations, so asking them to put your socks on or turn your telly round or whatever. I thought it wasn’t really in their remit. But then you realise that their remit is really to assist you, in your care, safety, happiness, mental and physical. Once you learn that, your hospital stays is a lot better.”* (Steve) |
| Staff knowledge | Steve, Philip, Luke, Janet, Frank, David, Ken, Sheila | Dismissing concerns due to more expertise | *“She goes, she said, ‘Just go to sleep. I've been a nurse for 27 years’. She says ‘I know what I'm doing’”* (David) |
| Experience and skill as a positive | *“But because the nurses see people go through the system so much, they’re as close to understanding as they’re ever going to be without physically going through it.”* (Steve) |
| Perceptions of self and autonomy | Sense of self as an individual | Steve, Philip, Luke, Janet, Frank , David, Ken, Sheila | Lack of knowledge of own story | *“And what I'm saying is what they told me now that they have resuscitated me because I had passed out”* (Sheila)  *“I don't remember anything except that I came round in intensive care and I had a lot of morphine”* (Janet) |
| Changes in self | *“It's just adapting to being disabled and I don't like it a bit. But when I do achieve a little baby something, it's very cheering.”* (Janet)  *“That is upsetting really because I used to have [describes body prior to injury]. And now it’s [describes body now]. I can't bear that really.”* (Janet) |
| Being seen as an individual/personal preferences | *“I’ve always been very well presented and I don’t want that to stop in hospital. People around you that want to help keep your standards. That helps you feel safe as well.”* (Steve) |
| Own coping skills | *“But I kind of put the, I'm totally dependent on these people here and it's really scary, I just put that to the back of my mind and thought well they do it every day.”* (Ken)  *“But we took some people will say, well, if you have that much faith, why can't you be healed? You know why? Why you? Why does he have to make you go through that, please? Like when I say it is for a reason. So I do believe that”* (Philip)  *“LR: Yeah, what helps get you through it? Luke: It’s gotta be my wife. Visiting me every day. She came to every meeting. I’m proud of her, I’m very fortunate. And my very good friend supported my wife. Felt very reassured and I’m very fortunate.”* (Luke) |
| Unfamiliarity of situation | Steve, Philip, Luke, Janet, Frank, David, Ken | Lack of personal reference for situation | *“If there’s fear, it’s fear of the unknown really. And the more you know, the less you fear. And the safer you feel.”* (Ken)  *“Because it's not where we go very often, is it?”* (Steve) |
| Nights being difficult | *“I found the nights very hard. I wasn’t looking forward to the night staff coming on. It used to make me feel apprehensive you know, wondering which of couple were coming on”* (David)  *“So yeah, nights were awful at the [first hospital].”* (Frank)  *“And it's worse in the dark somehow”* (Janet) |
| Lack of stimulation on bedrest | *“And it’s what happened, I couldn’t do anything, just lying there, staring at the wall, lying there with the thoughts going through my head, will I be able to walk?”* (Philip).  *“Yeah, six weeks proper backrest, bedrest looking at the ceiling”.* (Frank) |
| Autonomy | Steve, Luke, Janet, Frank, Ken, Sheila | Lack of choice | *“Before mobilisation is, is the most dangerous and worrying part from the patient's point of view”* (Ken)  *“You can't go to anyone and you’re reliant on the buzzer”* (Steve). |
| Independence | *“‘No I’m alright’. Yeah. That person wants to be independent. I don't at the moment.”* (Steve)  *“You lose your independence. Whilst the relevant safety things are there. I can’t text. I can’t press the buzzer, I can’t use my phone. So there you’re losing your strength of safety, your lack of ability to do things you used to do, I can’t just pop by or put myself into bed.”* (Steve) |
| Dependence on others | *“When you’re in hospital, it’s like that. Every patient is not the same. Really do find that. If they’re fixing me the way they’re fixing that woman over there, it doesn’t work. I might say, you need to put an extra pillow there, so you know yourself but you need them to take care of you.”* (Philip)  *“And I did six weeks go completely flat on my back bedrest. So all I could see of the world is, you can't see faces, people come and sit down next to you and talk to you. You can't see faces. You can't recognise people unless they're right over your head. Which was difficult because they're the people looking after you. I was completely dependent on the ward staff.”* (Ken).  *“I'm totally dependent on these people here and it's really scary.”* (Ken). |
| Involvement in own care | Steve, Luke, Janet, David, Ken, Sheila | Learning new skills | *“But when I do achieve a little baby something, it's very cheering”* (Janet). |
| Directing own care | *“…just got on with it. Got into the routine. Didn't think too much about the consequences. Because I knew I was going to get well enough from the first two or three weeks”* (Ken). |
| Impact of others on the ward | Sharing space with unknown others | Steve, David, Sheila | Help from others | *“And it’s quite strange as well that we're all in the same boat. And that no one can help each other. They can press their buzzer, which in the ward, in the bay we do for each other.”* (Steve)  *“And she said I'm going to help you finish that food. And she spoon fed me.”* (Sheila) |
| Shared experience | *“The night before when me and [name] were on the other ward, we were up till 11 o'clock playing cards like you know.”* (David) |
| Sharing space with unknown others | Steve, Luke, Janet, David, Ken | Comparison to others | *“Do you think you'll ever walk again? And it really dawned on me. No, I very probably will never walk again. So then I cried a bit. How tactless can someone get?”* (Janet). |
| Witnessing abuse | *“Verbal abuse, physical abuse. If they could catch a nurse within range. They either give her a punch or a kick. Absolutely awful.”* (Ken) |
| No choice in who you are sharing space with | *“Do you think you'll ever walk again? And it really dawned on me. No, I very probably will never walk again. So then I cried a bit. How tactless can someone get?”* (Janet) |
| Impact of family/visitors | Steve, Philip, Luke, Janet, Ken | Involvement in care | *“And if I was worried about anything, they'd go away and talk to the ward staff and find out exactly what we were doing and why we're doing it. Because early on in the six weeks I wasn't capable of stopping them and asking myself.”* (Ken)  *“My physio was there and they’d be watching her, so that on the days they didn’t come, she could do the physio. Well, certain parts. She could massage my hands.”* (Luke)  *“And if I was worried about anything, they'd go away and talk to the ward staff and find out exactly what we were doing and why we're doing it”* (Luke) |
| Morale | *“And it was Covid, and that one visitor comes to visit for 2 hours everyday … And it was. It was hard.”* (Philip)  *“I mean, quite regular visitors were allowed in as there was no restrictions on really on visitors to speak of. So they were just allowed to come in anytime they wanted. So that was good.”* (Frank) |
| Availability of resources | Impact of physical environment | Steve, Philip, Luke, Janet, Frank, David, Ken | Routines | *“They've obviously got all the lights on, but just leave the doors open. So the place was flooded with light. So lack of control of the environment caused the frustration… And at that stage in your recovery, the early acute stage, sleep is probably one of the most important things for healing.”* (Ken) |
| Having non-medical spaces | *“The garden spaces were nice to escape to cause it's not like a hospital environment.”* (Steve)  *“I thought I'm just in a canteen, anywhere in the world. I knew there was, I felt safe because there was medical staff there.”* (Steve) |
| Equipment provisions | *“And I couldn't press a button and I asked for a softer one and they couldn’t find one. So I had to shout out in the night”* (David) |
| Physical safety measures | *“How safe do you feel in hospital? Well, really to answer that I feel really safe because I've got rails on the side of my bed”* (Steve) |
| Staffing levels | Steve, Philip, Luke, Janet, Frank, David, Ken | Awareness of current climate | *“Staffing levels were bad, nowhere near enough staff.”* (Frank) |
| Impact on physical health | *“So yeah, the lack of care also, I ended up with a bedsore as well from, because of the lack of care at the [first hospital], unfortunately.”* (Frank) |
| Feeling like a ‘tick box’ | *“You say you have set, set of things you must meet. OK, so we have to be turned every three to four hours. So we've just become a KPI. The whole process. We're not humans anymore.”* (Steve)  *“You know, they come in, they whack the breakfasts out and they go on to the next bay. Because they've got so many people to feed in a certain time.”* (Ken) |