



The psychiatric ward environment and nursing observations at night: A qualitative study

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Accessible summary

What is known on the subject?

- Nursing observations at night are conducted on psychiatric wards to ensure the safety and well-being of patients as well as to reduce the risk of suicide or severe harm.
- To our knowledge, no studies have examined the lived experience of the psychiatric ward environment and of nursing observations at night.

What does the paper add to existing knowledge?

- The main complaint from patients was the constant interruption of their sleep, as most of the patients in this study were observed 2–4 times an hour. Their sleep was interrupted by (a) the light from torches shone into their faces by staff checking on their safety, (b) the noises produced by the opening and closing of bedroom/ward doors, and/or (c) staff talking to each other during the observation. Patients also reported that they found having somebody enter the room in the middle of the night intimidating and unsettling.

What are the implications for practice?

- Poor sleep has been associated with an increase in suicide risk and mental health problems.
- Identifying practices that promote sleep hygiene is vital.
- The study could be used to develop a Quality Improvement Project to improve patients' sleep and perhaps reduce duration of stay.

Abstract

Introduction: A fundamental component of nursing care is observations at night to ensure the well-being of patients. However, there is no literature on the lived experience by inpatients of such observations or of the general environment of a psychiatric ward at night.

Aim/Question: This study aims (a) to understand the lived experience of being an inpatient on a psychiatric ward at night with a focus on intermittent observations and (b) contribute to developing a tool to monitor the psychiatric ward environment for use in quality improvement projects.

Method: Semi-structured interviews were conducted with twelve inpatients from five psychiatric wards who had experienced intermittent observations at night. These interviews were subsequently transcribed and analysed using content analysis.

Results: Environmental disturbances including light and noise, invasion of privacy and safety considerations on the ward all contributed to sleep disturbance. The unintended consequences of disturbances caused by intermittent night observations, and by staff in general and other patients formed the core of the inpatients' experience. We developed a clinical tool that could be used to identify the factors that are relevant on an individual ward.

Discussion: Participants interviewed unanimously agreed that poor sleep quality had a significant negative impact on their psychological and social well-being. These were discussed in relation to the environment and the experience of observations at night.

Implications for nursing practice: Deprivation of inpatients' sleep is currently under-reported, and the usefulness of intermittent observations at night in psychiatric wards is questioned. Much could be done to adjust the environment at night to support quality sleep and improve psychiatric symptoms. This paper aims to highlight the lived experience of patients to help bring improvements.

KEYWORDS

acute mental health, patient experience, qualitative methodology

1 | INTRODUCTION

This study focusses on understanding patients' lived experience of a psychiatric ward environment at night while being under intermittent observations.

Psychiatric nursing observation is defined as "...regarding the patient attentively, minimizing the extent to which they feel they are under surveillance, encouraging communication, listening, and conveying to the patient that they are valued and cared for..." (Bowers, Gournay, & Duffy, 2000; Standing Nursing & Midwifery Advisory Committee, 1999). National Institute for Health and Care Excellence (2015) in the Violence and Aggression Guideline, define various levels of observation determined by a risk assessment. These include *continuous* observation by one or more staff; low-level *intermittent* observation (usually a frequency of between once or twice an hour); and high-level *intermittent* observation (usually two to four times an hour). The importance of engagement (i.e., the emotional and psychological containment of distress and giving hope) is emphasized as a genuine not just a linguistic alternative to observation which may be deemed to be counter therapeutic (Cardell & Pitula, 1999; Cutcliffe & Barker, 2002; National Institute for Health & Care Excellence, 2015). However, "engagement" is not usually required at night when patients need to sleep and to be kept safe. The difference in the purpose or frequency of day and night observations is under-reported in the literature. A variety of practices and frequency of observations may be used at night to document that a patient was safe at a certain time. The Engagement and Observation Policy (Burleigh, 2017) and the Therapeutic Observation and Positive Engagement Policy (Adcock, Pemberton, Leonard, Weedon, & Preedy, 2019) used in inpatient services within psychiatric wards require the staff member to clearly see that a patient is breathing while ensuring that nothing is impeding them. At night, this procedure might involve

either opening the window hatch on the door, entering the bedroom and shining a torch on the patient, switching on a light or, if the patient is unresponsive, shaking them to establish they are still conscious. The aims of night observations are therefore a method of assessing patients' well-being as well as any potential risk that might arise in the form of severe self-harm or suicide.

A systematic search of the literature on the environment and nursing observations at night revealed few studies conducted on a psychiatric ward. A meta-analysis identifies the problems of sleep deprivation through noise on medical wards (DuBose & Hadi, 2016). There are also studies identifying that the large majority of psychiatric inpatients experience insomnia without focusing on the determinants (Haynes, Parthasarathy, Kersh, & Bootzin, 2011; Horne, Hay, Watson, & Anderson, 2018; Keeley, 2010; Muller, Olschinski, Kundermann, & Cabanel, 2016). Improving sleep is important because sleep deprivation makes a psychiatric disorder worse (Krystal, 2012) and increases the risk of suicide (Malik et al., 2014). Importantly, sleep duration is negatively correlated with subsequent length of time in hospital (Langsrud, Vaaler, Kallestad, & Morken, 2016). The treatment of insomnia has been shown to lessen psychotic experiences (Freeman et al., 2017), mania (Harvey et al., 2015), depression and anxiety (Ye et al., 2015). Adapted Cognitive Behaviour Therapy (CBT) for insomnia reports promise in psychiatric inpatient wards (Sheaves et al., 2018). In the Sheaves et al. study, patient preferences (e.g., window hatch to be left open at all times or a dim light to be on through the night) were sought to minimize sleep disruption by observations at night. However, no details are provided on the effectiveness of these specific interventions, as it was part of an overall package for improving sleep.

In summary, psychiatric ward environments are not conducive to sleep. The current project was therefore driven by the lack of reported lived experiences of inpatients in psychiatric wards at night. The aims

of this study are therefore (a) to understand the patient experience of being an inpatient at night and (b) to generate items for a clinical tool to monitor the ward environment for use in quality improvement projects.

2 | METHOD

2.1 | Research team

The interviews were conducted by one of the authors (SA) as part of her MSc student research project. No relationship was established with the interviewees prior to commencing the interview. Interviewees were told that she was interested in their personal experience of nursing observations and the ward environment at night in order to help improve future patient care.

2.2 | Study design

The design of this study used semi-structured interviews to understand the experiences of patients in psychiatric wards (see Appendix 1). This qualitative method provides us with an opportunity to explore and describe in detail the lived experience of being on a psychiatric ward at night.

The participant selection was completed through purposive sampling. The sample was selected from five wards in four different hospitals; however, four of the patients shared their experiences from several other wards where they had been admitted. In total, 13 different wards were discussed during these interviews. Thirteen patients who were at that time sufficiently mentally stable to be interviewed and had capacity to provide informed consent were assessed by the nursing staff and invited to take part in the study. All but one agreed to take part and were introduced to the researcher. They were given a short presentation and information sheets regarding what the study entailed. All participants provided informed consent and were informed of their rights to withdraw from the interview at any point and were reassured that their data would be discarded. The final sample consisted of 12 participants (females: $n = 4$; males: $n = 8$, with an age range between 21 and 64 years of age). None of the participants dropped out of the study.

The eligibility criteria included being within the age range of 18–65 and under intermittent observations at night. Participants were excluded if:

1. They were psychiatrically too disturbed (e.g., they were thought disordered or too agitated) to be able to engage in a research interview or were unable to provide informed consent.
2. There was a suggestion of significant cognitive impairment or learning disability.
3. The participant had an insufficient command of English to participate in qualitative research without an interpreter.
4. The participant had an untreated sleep disorder caused by a physical problem such as obstructive sleep apnoea, restless leg syndrome or narcolepsy.

The interviews were conducted in a quiet room within the wards to ensure participants' privacy and comfort as well as providing them with a safe place where they could freely express themselves without being interrupted. Confidentiality was maintained by including only the researcher and the interviewee in each session.

The interviews followed a list of open-ended questions and topics that had been pilot tested prior to commencing the study (see Appendix 1). Further prompts were provided by the researcher when required. Repeat interviews were not carried out. Each interview was audio recorded with Voice Memos App (IOS), and field notes were collected. Each interview session had an average duration of 30 min. We asked the patients at the end of each interview if they had anything else to add and by discussing with the principal investigator the limit reached regarding the development of subsequent categories. The transcripts were not returned to participants for comments or corrections.

2.3 | Data analysis

The collected interviews were recorded, and the answers transcribed verbatim by the second author (SA). These transcripts were then analysed using the content analysis with open coding procedure as described by Elo & Kyngäs (2008), where categories are derived from the data by the third author (AP). This procedure included (a) familiarization with the data and identification of initial codes (units of meaningful text relevant to the research topic), (b) organizing the qualitative data through open coding, (c) grouping list of categories generated into higher order headings, (d) perform abstraction by formulating a general description of the topic through the generation of categories and (e) reporting the categories (Figure 1). The final content analysis was comprised of 27 codes, which were grouped into three generic categories.

2.4 | Ethics

A favourable opinion was provided by Coventry & Warwickshire Research Ethics Committee (REC reference 17/WM/0395). The participation of patients was voluntary, and data collection was conducted confidentially and anonymously. All participants had capacity to give informed consent and were given personally to the researcher.

3 | RESULTS

3.1 | Sample characteristics

Twelve patients from four different psychiatric wards across London participated in this study of whom 5 (42%) were detained under the Mental Health Act and 7 (58%) were voluntarily admitted. Patients had received a variety of psychiatric diagnoses. All patients were

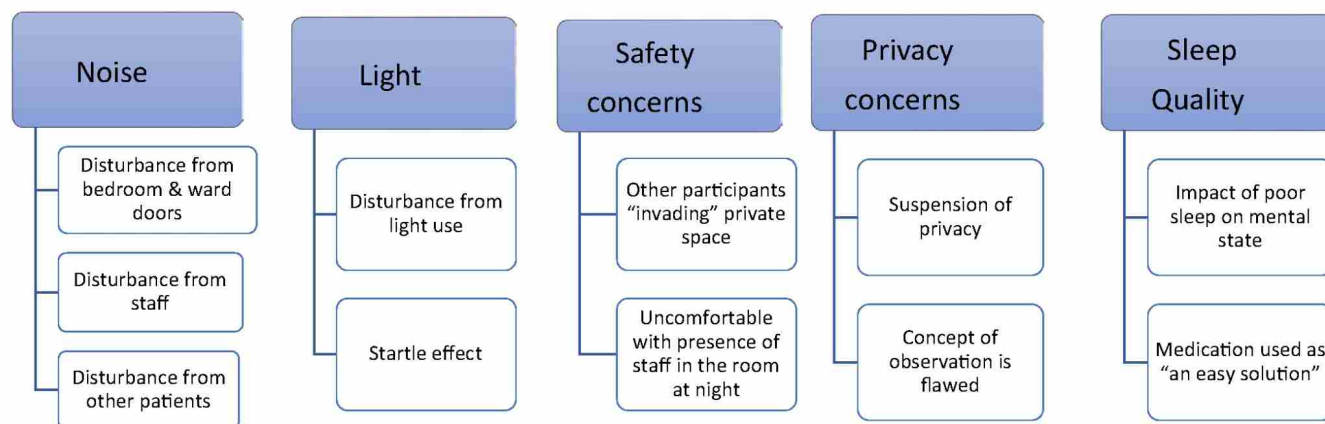


FIGURE 1 Mental health patients' experience and perception of night environments in wards: themes and sub-themes [Colour figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com/doi/10.1111/jpm.12583)]

currently or had in the past been under intermittent observation between 1 and 4 times an hour. The ethnic background of this sample was mainly White British (69.2%), with the rest being Black African (23.1%) and Asian Indian (7.7%).

3.2 | Experience of the night environment in wards (interview)

Interviews began by asking patients to provide a summary of their experience at night on a psychiatric ward compared to their own home. Patients reported that they either found it very difficult to sleep at night in the wards - "because of the nature of the place, 17 people all with different problems, our sleep patterns are not the same I can get 3-4 disturbances in an hour" (Participant 6), or they required medication to help them sleep, - "I am more likely to need medication to sleep in the wards compared to at home" (Participant 4) or they were content with the conditions because of a lack of better alternatives - "staying here (ward) is far better than being homeless" (Participant 12).

The interview continued by considering the role of nursing staff in relation to the sleep experience of patients in night wards. Patients were not always aware of the purpose of night observation and often considered it unnecessary for them, while being of benefit for other patients. An exception to that was a patient who reported, "It was necessary, but it didn't really stop me from hurting myself" (Participant 1).

Further analyses of the interview data yielded three generic categories: (1) environmental disturbances, (2) The experience of spending the night on a psychiatric ward as a patient and (3) emotional well-being (see Figure 1).

3.2.1 | Category 1: environmental disturbances from observations

Sleep disruption due to observational procedures

All patients negatively reported the opening and closing of bedroom doors during night observations. They described this procedural

behaviour as startling. It increased their anxiety, decreased their ability to relax and negatively impacted their emotional well-being.

They should have soft closing for the doors so that they stop slamming. The doors make me jump... with the loud banging... and this worsens my anxiety.

(Participant 8)

Another procedure of which all patients expressed an overall disapproval was the use of light during night observations. They reported being severely disturbed by the use of torches or by bedroom lights being turned on without warning.

I probably didn't really go to sleep. They kept coming in every 15 minutes. Sometimes they turn the florescent room lights on in the night, that's horrible. They would turn the light on until I made some movement or showed I am ok. Sometimes they would use torches as well but better than lights being turned on.

(Participant 1)

Descriptions of night observations were always followed by a reference by the interviewee to the negative impact it had on their emotional state. In some patients, this contributed to a constant state of anxiety and a feeling of being unsettled.

The nurses try to use a lower voltage bulb in an attempt not to startle you. But when the room is dark to begin with any light looks so bright.

(Participant 6)

Startling is when they come in and I see a silhouette, it really frightens me!

(Participant 7)

Staff behaviour as a cause of sleep disturbance

The disruption was mainly attributed to general staff behaviour such as "talking on their phones all night..., talking loudly amongst

themselveswatching tv" or even "shouting at each other ... and ... screaming at the sight of a spider." (Participant 1).

Further criticism of staff behaviour included noisy handling of keys to open and close doors. According to patient reports, the sound of clinking keys was particularly disturbing.

I mean the light was irrelevant because by the time they clanked the keys and banged up and down other doors in the corridor I was wide awake... Obviously the noise woke me ... because of the way the room is there is virtually nothing in it so it's like an echo chamber.

(Participant 13)

3.2.2 | Category 2: experience of spending the night on a psychiatric ward as a patient

Other patients "invading" private space

Another concern raised by the patients was the invasion of their personal space by other patients who "are unwell... and not at the same level as we are" (Participant 2). Such accounts included the following:

I have had patients coming into my room; this was unsettling and very scary ... because the patient had to travel quite a bit to come in my room and it makes me wonder why were they not stopped?

(Participant 7)

With one experience being:

One patient ... came in my room and at one point held me hostage and the nurses had to get me out.

(Participant 1)

These incidents could have a detrimental impact on the emotional state of a patient as some reported raised levels of worry and constant thoughts concerning their safety.

Sometimes patients are shouting and screaming, crying and some are aggressive; it's really unpleasant.

(Participant 7)

Uncomfortable with presence of staff in the room at night

Staff were considered at times as a threat by some patients who reported "not feeling safe during the observation" (Participant 8), especially when staff entered their rooms at night. One patient commented "when they come in and I see a silhouette it really frightens me" (Participant 7). This was not the general consensus, however, as some patients reported that familiar and friendly staff can be comforting and reassuring. One participant felt unsafe as "despite observation I still self-harmed" (Participant 1).

Suspension of privacy

The issue of privacy was raised by a number of patients, who did not feel comfortable with the current strategies implemented by the night staff. In particular, it was highlighted that "it's an odd experience when you see a person ... peering through at you" (Participant 3) and "it's worse ... to see a stranger (referring to agency staff) in your room in the middle of the night" (Participant 7). There were also some accounts about other patients not respecting privacy. One patient reported: "I didn't like all the patients staring at me which they tended to do to have a good look through the window" (Participant 13).

"Concept of observation is flawed." Patients' negative perception of observation was so strong that they were challenging the usefulness of night observations by reporting that "someone is constantly watching you" which makes you feel "like being in a fish tank" (Participant 7) and "loses the therapeutic relationship and trust you are supposed to be building" (Participant 12).

3.2.3 | Category 3: Well-being

Impact of sleep deprivation on emotional state

Patients reported a number of emotional issues such as feeling "unwell" (Participant 1), "groggy" (Participant 5) and "tired so I sleep during the day and don't get too much else done" (Participant 9). These feelings were deemed to be directly linked to the observation process as, "staff kept coming every 15 min ... startling me and waking me up at night" (Participant 8). This was an ongoing phenomenon as per the patients' reports "they'll (staff) wake me up again. Sometimes I am awake for hours! And then when you do get back to sleep, and finally sleep, it's time to wake up again!" (Participant 11). One patient compared the sleep deprivation experienced in wards to be similar to Guantanamo Bay saying; "we know how bad sleep deprivation is, look at Guantanamo Bay, they were tortured and could not sleep" (Participant 6).

Poor communication with staff

A number of patients reported the lack of communication between them and the nurses, despite of all the social activity described in the ward. They expressed feelings of loneliness and isolation in response to this lack of interaction. One patient highlighted:

There would be no interaction, even if I was awake, lying on the bed, they wouldn't talk to me... Very very very little interaction if any at all. If you went to seek interaction, most did not give me the time.

(Participant 7)

Patients also reported that they felt misunderstood as any symptoms originating from lack of sleep were completely disregarded by the nursing staff. When patients mentioned any type of distress caused by lack of sleep, the staff preferred to administer medication to alleviate the symptoms "If I was distressed, they'd (staff) resort in drugs than actually speak to me" (Participant 7) or induce sleep

"medication knocks me out... but I am still aware of everything that's going on" (Participant 6), rather than altering and/or adjusting some of the behaviours and procedures that caused the problem initially.

At the end of each interview, participants were encouraged to provide their feedback regarding practices that might improve disturbances in night wards. Suggestions in respect to minimizing light disturbances included the use of night-vision glasses or a CCTV camera (only during night-time). Concerning the reduction of noise, suggestions included the following: installing floor coverings, using soft closing doors or applying foam to the doors to soundproof them. Recommendations for safety concerns included the installation of an alarm in the bedroom and for privacy concerns, neon gas windows which could be controlled by both staff members and patients.

The use of remote monitoring systems was also discussed with the majority of the patients (75%) finding the use of wearable devices measuring pulse rate, sleep and activity (e.g., Fitbit) acceptable; however, they were not as keen on a location tracker (only 33% found it acceptable).

The categories identified were used to develop a questionnaire to monitor the ward environment and impact of observations at night (Appendix 2). This could be used in a Quality Improvement Project to improve the quality of sleep on a ward. Ideally, the questionnaire would be used in conjunction with a light and decibel metre and measure of sleep quality to obtain more accurate estimations about the ward environment at night.

4 | DISCUSSION

This study explored the lived experiences of patients on an acute psychiatric ward during the night, specifically focusing on the effect of intermittent observations and the general environment on the quality of sleep. Central to the narratives of all interviewees were three main categories. The categories that predominated related to environment disturbances and particularly the procedures followed during night observations which led to poor quality of sleep.

The main category of these interviews was that of the unintended consequences of intermittent observations negatively impacting patients' sleep at night on a psychiatric ward. The category of the experience of spending the night on a psychiatric ward that emerged from the analysis presented two novel consequences of intermittent observations conducted at night. Patients reported that having staff entering their room at night when they were asleep made them feel very uncomfortable and vulnerable, especially where agency staff whom they did not know were conducting the observations. The procedures followed by night observations also resulted in patients feeling deprived of their privacy which had an impact on the therapeutic relationship with staff by reducing trust and potentially cooperation leading to worsening patients' symptoms prolonging their stay at the wards: as such, patients questioned the usefulness of observations at night. Consequently, their physical and mental health were also negatively impacted due to experiencing a constant state of anxiety, alertness and irritable mood. These effects have been previously

reported by Wood and Pistrang (2004) in relation to the general experience of being a patient on an acute psychiatric ward. Patients reported an overwhelming sense of vulnerability and helplessness, which was in line with reports from staff working in these wards.

Observations at night are a standard method of risk management. However, they can be disruptive and obtrusive, and potentially reduce or disrupt patients' sleep which could be a contributory factor of increased self-harm or delayed discharge.

Further findings of our study showed that participating patients overwhelmingly agreed that they experienced sleep deprivation at some point during their stay in a psychiatric ward. The sleep deprivation was mainly attributed to interruptions caused by intermittent observations that were accompanied by noises from doors opening and closing, as well as bright light torches used during the process.

These results are in line with surveys of psychiatric inpatients who have reported symptoms of insomnia due to noise and light usage during nursing observations (Horne et al., 2018; Muller et al., 2016) as well as research studies that have measured sleep objectively through the implementation of wrist activity monitors. These studies have found that the amount of sleep was highly correlated with noises produced by staff conversations, other patients, intercoms and pagers (Yoder, Staisiunas, Meltzer, Knutson, & Arora, 2012). A meta-analysis confirms these findings as it concludes that the continuous noise caused by nurse night activities in medical wards lead to poor sleep conditions for the patients (DuBose & Hadi, 2016). Sleep disruptions have also been reported in intensive care units and surgical wards (Norton, Flood, Brittin, & Miles, 2015) in relation to environmental factors mainly attributed to noise. Patients have been reported to experience fragmented sleep for up to 5 hr per night (Horne et al., 2018). The constant interruptions also influence the quality of sleep as patients are unable to reach deeper stages of sleep (Elliott, McKinley, & Cistulli, 2011). A number of studies have established that poor sleep is associated with a range of physical and mental health problems (Reid et al., 2006). More specifically intermittent sleep deprivation has been shown to cause negative changes in the neuroendocrine, immune and inflammatory systems (Norton et al., 2015) as well as hypertension (Bathgate, Edinger, Wyatt, & Krystal, 2016; Fernandez-Mendoza et al., 2012; Vgontzas, Fernandez-Mendoza, Liao, & Bixler, 2013). Further evidence from correlational and experimental studies has demonstrated that reduced sleep has a severe impact on emotional regulation (Babson, Trainor, Feldner, & Blumenthal, 2010; Talbot, McGlinchey, Kaplan, Dahl, & Harvey, 2010) and negative mood as well as circadian rhythm disruption (Arendt, 2000). Sleep deprivation and worsening of symptoms through the usage of night observations might be justified if the rate of severe self-harm, suicide, violence and absconding was very high. Data from the National Confidential Inquiry, however, show that between 2011 and 2016 there were 464 inpatient suicides reported with approximately 16% of them taking place during the night (Veale, 2019). No controlled trials have been conducted to determine how many suicides or episodes of severe harm have been prevented or increased because of intermittent observations.

5 | IMPLICATIONS FOR NURSING PRACTICE

One outcome of this study is to question the *routine* use of intermittent observations at night and the lack of flexibility in altering intermittent observations during the day to general observations at night. The aim of observations is to keep patients safe. However, an unintended consequence of intermittent observations at night is that sleep deprivation may increase the risk of self-harm as suggested by a recent systematic review and meta-analysis (Malik et al., 2014). Therefore, if patients are judged to be at immediate risk, then they should be placed on constant observation. If they are not, then optimizing sleep is important for treating the psychiatric disorder and they should be placed on general observations at night. If intermittent or constant observations are to be used at night, then it would be helpful to evaluate other interventions and practices that allow patients to sleep and be kept safe. Wearable devices that measure pulse rates, sleep and activity are now used by millions of people. Indeed, general hospital wards have used remote monitoring systems for some years. For example, following surgery when patients need to be left as much as possible to experience restful sleep, vital signs including temperature, pulse and respiration, ECG traces, saturated oxygen levels can be remotely monitored at a nursing station at some distance from the patient's room. Other vital signs may also be monitored in this way and could in theory immediately alert staff to a serious adverse event (e.g., asphyxiation) or removal of a device. Such wearable devices could therefore be used in patient wards to facilitate observation and provide important objective information such as sleep quantity and quality and level of arousal. When the usage of such devices was discussed with the patients of this study, the majority expressed a positive outlook for their implementation. Further research is required to determine the acceptability of devices and the number of false positives.

Although there is considerable variation in the nature of inpatient psychiatric wards across the world, with differences in the background, education and training of mental health nurses, the matters of observation and the prevention of suicide are a well-recognized issue in the literature. The NICE guidelines, the first version of which was published in 2005, were the first to provide detailed guidance of the process of observation and matters of context. Internationally, one example of observation guidance is to be found in Australia, where observation levels are very similar to those defined in NICE Guidance. The Department of Health Guideline for the State Government of Victoria "Nursing Observation Through Engagement in Psychiatric Inpatient Care" (Department of Health Guideline, 2013) draws attention to night-time observation. It is particularly noted: "When deciding upon observation levels, senior nurses and treating psychiatrists should determine whether it may be appropriate to use lower levels of observation. In some situations, less intrusive forms of observation may enable better sleeping patterns in people who are hypervigilant or who may awaken or be startled... Whatever the clinical indicators suggest, the person being observed should be aware of what type of observation will occur at night."

Our results and previous surveys indicate a need to improve sleep on psychiatric inpatient wards. While it may be possible to develop digital wearables in the future, it should be possible to improve the ward environment now.

A Quality Improvement Project (QIP) for improving sleep has been conducted on acute medical and surgical wards by Norton et al. (2015). Some of their suggestions and the patient suggestions from this study could be incorporated or adapted for a psychiatric ward. We identified in our study noise and light as being the major determinant factors of sleep deprivation, and it should be possible to develop a "Sleep Quality Improvement" policy for psychiatric wards by noise and light and the routine use of intermittent observations in psychiatric ward settings.

5.1 | Limitations

The results from this limited sample should be followed by a larger and possibly more representative population in a quantitative study. The study may be limited as the data obtained might be characterized by a recall bias, because interviews were not necessarily conducted when participants were under observation at night. It is possible that researchers were biased in their beliefs and assumptions about the problems of sleep deprivation, although these had already been influenced by informal discussion with patients. Accounts from nursing staff should also be collected to compare with patients' experience to obtain a broader perspective of the ward environment at night.

6 | CONCLUSION

Previous studies have highlighted the poor quality of sleep in psychiatric inpatients. Our study has highlighted that factors impacting sleep quality included environmental disturbances such as noise and light which were related to nursing observations. In this study, the unintended consequences of night observations on patient's sleep quality were further explored. The findings were in line with previous studies as it showed sleep deprivation being related to noise and light, with the newest finding being that night observations negatively impact the sense of safety and privacy for inpatients. The implications of this research are threefold; improvement in the environment of psychiatric wards is urgently needed, emphasis should be placed on developing and implementing a checklist to ensure the improvement of sleep quality for patients as well as reducing the routinely use of intermittent observations at night.

7 | RELEVANCE STATEMENT

Nursing observations are used in psychiatric wards to keep patients safe at night. In this study, night observations and the environment in general were severely criticized by the patients for leading to sleep deprivation. We argue for the development of policies to

improve the environment of psychiatric wards and to adapt nursing observations at night.

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ETHICAL APPROVAL

A favourable opinion was provided by Coventry & Warwickshire Research Ethics Committee (REC reference 17/WM/0395; IRAS Project ID 234551).

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APPENDIX 1

TOPIC LIST FOR INTERVIEW

For how many days have you been an in-patient? What sort of ward is it? Are you a voluntary patient or detained on a Section of the Mental Health Act?

In a moment, we'd like to discuss your nursing observations at night. However, first I'd like to get a general picture of what's it like to sleep on your ward at night compared to being at home. How have you slept on the ward?

(If the person had a problem sleeping generally) Was it difficulty getting to sleep at all, or being awoken and then being unable to get back to sleep or something else?

How big a problem was each of the following in affecting your general ability to sleep?

Turning now to the observations by nursing staff:

For how many nights were you observed?

Was this on intermittent or constant observation at night (discuss each separately)?

(If intermittent observation) Do you know how often you were being observed at night by staff?

(If constant observation) What did this consist of?

Was the purpose of the observations explained to you by staff?

(If not, what did you understand was the purpose of the observations?)

Do you know if the staff assessed you as at risk of committing suicide or severely harming yourself, or something else?

Did you think observing you at night was necessary? (If not, why not?)

Do you think observations at night are ever necessary for other patients? (If not, why not?)

(If intermittent) Please describe how you were observed at night (e.g., did the nurse shine a light in your face or open the door or what?)

Did the nursing observations startle or wake you at night? If so, how often were you disturbed?

How big a problem was each of the following for you at night when a nurse was checking your safety?

Did anything else in the nurse's behaviour interfere in your sleep?

Were you able to get back to sleep again easily?

Do you feel that observations at night had any impact on the way you felt the following day? (in what way?)

Do you feel that nursing observations at night might influence your decision to seek help in the future?

Given that observations may be necessary for some patients, how could observations at night be improved to keep you safe and not disturb you at night?

What do you think of the idea of staff using a torch with an amber light that would not wake you?

How would you reduce the sound outside your room or the noise of the nurse walking?

Would you find it acceptable to wear a device around your wrist that transmitted your heart rate? What about having your location tracked?

What's your experience with nursing observations during the day? (Do staff talk to you to find out how you are?)

Thank you!

APPENDIX 2

EXPERIENCE OF NIGHT ENVIRONMENT ON THE WARD

Instructions: Circle the number which best describes your experience

	Not at all a problem	Minor problem	Moderate problem	Serious problem
<i>Part 1: Please rate the following according to how much your sleep was disturbed by staff during night observations</i>				
1. Light used by staff (e.g., torch)	1	2	3	4
2. Light in my bedroom switched on	1	2	3	4
3. Noise created by staff when opening my door/hatch	1	2	3	4
4. Noise created by staff walking into my bedroom	1	2	3	4
5. Noise created by staff when carrying keys	1	2	3	4
6. Noise created by staff talking or shouting	1	2	3	4
7. Staff shaking me	1	2	3	4
8. Lack of privacy from staff	1	2	3	4
9. Feel unsafe when staff enter my room	1	2	3	4
10. Staff entering my room are strangers	1	2	3	4
11. No communication with staff when I am awake	1	2	3	4
<i>Part 2: Please rate the following according to how much impact do general disturbances on the ward have on you</i>				
1. Light on the ward (e.g., hallway lights)	1	2	3	4
2. Noise created by staff/patients talking or shouting	1	2	3	4
3. Noise created by staff/patients closing doors	1	2	3	4
4. Lack of privacy in my room (e.g., door window, CCTV etc.)	1	2	3	4
5. Feel unsafe due to patients entering my room	1	2	3	4
6. Any other issues? Please write below	1	2	3	4