ORIGINAL ARTICLE

Ways of understanding nursing in psychiatric inpatient care – A phenomenographic study

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Abstract

Aim: The aim was to describe the ways that nursing staff in psychiatric inpatient care understand nursing.

Background: Nursing in psychiatric care is marginalized with ambiguous role definitions and imperceptible activities. Nurse managers' capabilities to establish a direction and shared vision are crucial to motivate nursing staff to take part in practice development. However, before establishing a shared vision it is important to identify the different ways nursing can be understood.

Methods: Sixteen individual semi-structured interviews with nursing staff members were analysed using a phenomenographic approach.

Results: Five ways of understanding nursing were identified. These understandings were interrelated based on the way that the patient, nursing interventions and the goal of nursing were understood.

Conclusion: The diversity of identified understandings illuminates the challenges of creating a shared vision of roles, values and goals for nursing.

Implications for Nursing Management: Awareness of staff members' different understandings of nursing can help nurse managers to establish a shared vision. To be useful, a shared vision has to be implemented together with clear role definitions, professional autonomy of nurses and support for professional development. Implementation of such measures serves as a foundation to make nursing visible and thereby enhance the quality of patient care.

KEYWORDS

nursing, nursing management, phenomenography, psychiatric inpatient care, shared vision

1 | INTRODUCTION

Nursing in psychiatric care has been accused of a lack of autonomy and becoming instrumental by acquiescing to the medical model, mostly focusing on delivering treatments prescribed by physicians (Bladon, 2017; Lakeman & Molloy, 2017). Specifically, nursing has been described as having a marginalized status (Holmberg, Caro, & Sobis, 2018), unclear role definition (Delaney & Johnson, 2014) and being invisible (Harrison, Hauck, & Ashby, 2017), all of which has led to difficulties in implementation of theories and models (Barker, 2001; Bladon, 2017). Furthermore, psychiatric inpatient care is often confusing from the patients' perspective, creating difficulties to

understand the meaning and content of care (Lilja & Hellzén, 2008; Molin, Graneheim, & Lindgren, 2016).

Good leadership is imperative to meet the challenges in improving nursing practice, to secure clinical competence and the values of nursing (Cleary, Horsfall, Deacon, & Jackson, 2011). Leadership is not only crucial to strengthen the autonomy and professional development of nurses (Holm & Severinsson, 2010; Mrayyan, 2004), but nurse managers also need to establish a direction and shared vision to enable staff collaboration and thereby secure patient safety and quality of care (Martin, McCormack, Fitzsimons, & Spirig, 2014a, 2014b). Shared values, providing moral direction and defending humanism are seen by staff in psychiatric care as central elements for good nursing practice (Gabrielsson, Sävenstedt, & Olsson, 2016).

A shared vision of roles, values and goals can help nurse managers to motivate the nursing staff to practise development, that is the process of developing person-centred cultures (Martin, McCormack, Fitzsimons, & Spirig, 2014a, 2014b). Results of previous qualitative studies using a phenomenographic approach have revealed that nurses in the same clinical speciality understand their role and work in different ways. These results have been presented and discussed in models ranging from limited and task-oriented to more holistic understandings (Blomberg, Bisholt, Nilsson, & Lindwall, 2015; Jangland, Larsson, & Gunningberg, 2011; Kazimera-Andersson, Willman, Sjöström-Strand, & Borglin, 2015). In a meta-synthesis identifying different understandings of work among groups of health care professionals possible negative consequences of limited understandings of quality of care were discussed (Röing, Holmström, & Larsson, 2018). Röing et al. (2018) suggest that the varied understandings of work and professional roles can be used in competence development. Thus, the nurse manager has to identify the different understandings of nursing among nursing staff to begin the establishment of a shared vision of roles, values and goals (Martin et al., 2014a, 2014b). Available knowledge on the understandings of nursing in psychiatric inpatient care is lacking, however.

From this brief introduction, a shared vision of nursing seems to be a crucial starting point to enable quality nursing care. A fundamental question arises: How do nursing staff in psychiatric inpatient care understand nursing? To our knowledge, there are few phenomenographic studies with nursing staff as participants and no previous study describing the understandings of staff members in psychiatric inpatient care. An increased knowledge about these understandings might help nursing managers to establish a vision and motivate nursing staff towards a shared direction in psychiatric inpatient care. The aim of this study was therefore to describe the various ways that nursing staff in psychiatric inpatient care understand nursing.

2 | METHOD

2.1 | Methodological considerations

The qualitative research approach used in this study was phenomenography. The underpinnings of phenomenography are linked to the philosophy of phenomenology, as the basic assumption is that there is only one world, that is the world that is experienced. The object of research in both approaches is to reveal human awareness and experiences (Barnard, McCosker, & Gerber, 1999). However, phenomenology seeks to describe conscious and lived experiences of a phenomenon (Giorgi, 1999), while phenomenography assumes that phenomena, or aspects of reality, can be understood or experienced in a limited number of ways by a group of people (Barnard et al., 1999). As a research method, it allows the researcher to study variations in how the phenomenon is understood and experienced (Dahlgren & Fallsberg, 1991; Marton, 1981). Phenomenography makes a critical distinction between what is referred to as the first- and second-order perspective. The first-order perspective focuses on facts about a given phenomenon, as in phenomenology where the world is described as it is (Barnard et al., 1999; Giorgi, 1999). The second-order perspective centres on how the phenomenon can be experienced or understood and aims to describe the phenomenon as it is understood, and explore what it (for instance nursing) is for the participants (Marton & Booth, 1997). This second-order perspective is essential from a phenomenographic research approach because it makes it possible to examine how a phenomenon can be experienced or understood collectively and how it can be looked upon as a complex of the different ways it is experienced and understood (Marton, 1981).

2.2 | Ethical considerations

The study was approved by the Regional Ethical Review Board. All nursing staff members in the study were informed that participation was anonymous and voluntary and that they could withdraw at any time without reason or consequences. All study participants signed a written consent before participating. The transcribed material was coded and made anonymous. The study adheres to the consolidated criteria for reporting qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007).

2.3 | Setting

Psychiatric care for persons suffering from severe mental illness in Sweden is delivered in specialised psychiatric inpatient units at general hospitals (Mission Mental Health, 2018). Nursing staff in psychiatric care in Sweden consist of specialised nurses (registered generalist nurses with typically a 1-year master level education in psychiatric care), Registered Nurses, RNs (generalist nurses with a bachelor's degree) and nursing assistants. The level of health care education in the group of nursing assistants ranges from approximately 1 year at high school level to a minimum level of relevant health care education.

2.4 | Participants

The study was conducted at a psychiatric department at a university hospital in Sweden. Nursing staff from eight inpatient wards were invited to participate in the study. The eight wards sub-specialize in the

care of psychotic diseases, mood disorders, pain-related conditions and substance use disorders, as well as forensic care. Information about the study and invitations to participate were presented in conjunction with a survey. Thirty-four staff members showed initial interest to participate. From this group, 16 were chosen by purposive sampling to achieve maximum variation in professional role, sex and age. The characteristics of the study participants are described in Table 1.

2.5 | Data collection

The preferred method for gathering data in phenomenographic research is individual semi-structured interviews (Marton & Booth, 1997). There are interviewing techniques where the interviewer guides the participant through a range of questions based on the researchers conception of the topic. In a phenomenographic interview, however, the participant is prompted to identify and reflect on a particular experience regarding the phenomenon (Dall'Alba & Hasselgren, 1996). Individual interviews were conducted from June to September 2017 by one of the authors (JB), who is currently not affiliated with the university hospital. The interviews were held at the hospital in a room just outside the wards during the participants' working hours. An interview protocol was used that had been tested previously and contained background questions and the following three open-ended interview questions:

- Can you tell me about an encounter with a patient when you felt professional satisfaction?
- Can you tell me about an encounter with a patient that left you feeling professionally dissatisfied?
- What does nursing in psychiatric care mean to you?

TABLE 1 Demographic characteristics of the nursing staff

	n (%)
Sex	
Male	6 (38)
Female	10 (62)
Highest education	
University (health care)	6 (38)
University (other subject, single courses)	5 (31)
Vocational education	2 (12)
High school	3 (19)
Professional role	
Specialised nurse	3 (19)
Registered nurse	3 (19)
Nursing assistant	10 (62)
	Range (Mean; SD)
Age (year)	23–66 (46; 14)
Experience in psychiatric care (year)	1–31 (14; 9)

To enable optimal opportunity to gather reflections on a particular experience, the interviewer should encourage the participants to think and talk freely (Dall'Alba & Hasselgren, 1996). Hence, probing questions were included to encourage the participants to give detailed and exhaustive descriptions. The interviews, lasting up to 50 min, were audio recorded and transcribed verbatim.

2.6 | Data analysis

The data analyses were performed according to Dahlgren and Fallsberg (1991) by three of the current authors (JS, JB & MR). The process of analysis consist of seven steps: familiarization, compilation, condensation, grouping, comparison, naming and contrastive comparison (Dahlgren & Fallsberg, 1991). Each interview was analysed by the three authors individually and the results were then discussed in several joint meetings, until consensus was achieved. The authors began the analysis process by reading through the interviews carefully to get a sense of the whole. Each interview was then analysed separately. The most significant statements regarding the participants' feelings and thoughts about nursing in psychiatric care were identified, shortened and summarized. This process resulted in a preliminary description of the participants' understandings, what they focused on and what it had meant for
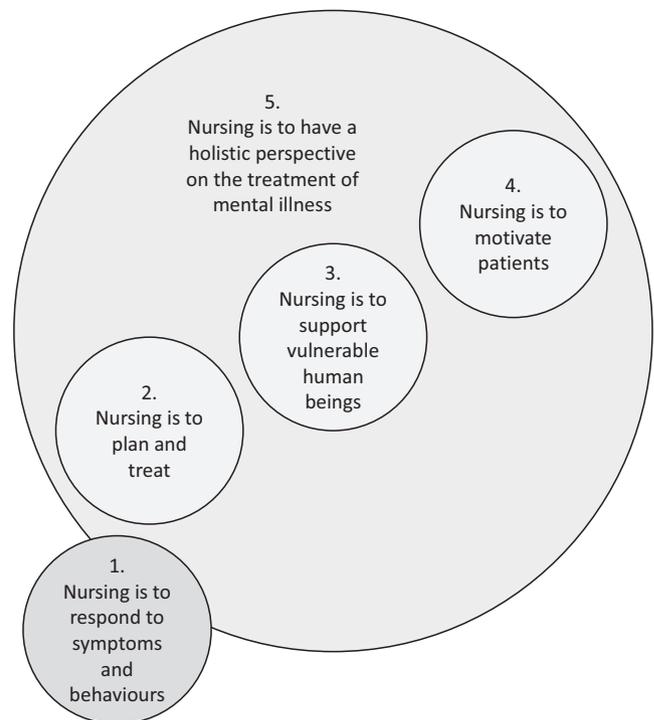

FIGURE 1 Outcome space: Categories of descriptions of the different ways of understanding nursing in psychiatric inpatient care. The outcome space illustrates the relation between the five categories of description. The most comprehensive category includes three of the other categories, which are based on partially shared descriptions of the patient, nursing interventions and the goal of nursing. The first category is only partially incorporated in the more comprehensive category because of the limited descriptions as compared with the other four categories

them personally. This procedure was repeated for each interview. Looking for similarities and differences, preliminary understandings were then compared with each other. Understandings with similar focus and meaning were grouped together and labelled as 'categories of description', depicting five qualitative ways in which nursing had been understood in this group of participants. All of the above steps in the process were conducted according to Dahlgren and Fallsberg (1991). Finally, a figure, or 'outcome space' (Figure 1) was constructed to mirror the internal relationships between the descriptive categories (Marton & Booth, 1997); this figure represents similarities and differences between the understandings (Barnard et al., 1999; Marton, 1981).

3 | RESULTS

The following results represent how nursing staff understand the real-world phenomenon 'nursing' in psychiatric inpatient care. The analysis identified five categories of description, reflecting five qualitative ways of understanding nursing in psychiatric inpatient care: Nursing is to respond to symptoms and behaviours, Nursing is to plan and treat, Nursing is to support vulnerable human beings, Nursing is to motivate patients, and Nursing is to have a holistic perspective on the treatment of mental illness. The categories and how they are related to each other are presented in the outcome space (Figure 1) and further described and illustrated by quotations from the numbered interviews as follows.

3.1 | Nursing is to respond to symptoms and behaviours

In this category, focus is on psychiatric diagnoses and symptoms. Patients are seen as objects of treatment who have different diagnoses and symptoms.

The focal point of nursing in this category is the patients' behaviours. The primary goal is to help the patients to adapt their behaviour to fit into society. Maintaining strict rules, keeping things in order and watching over patients and the ward were stated as important nursing interventions to attain that goal. However, staff members described the importance of accomplishing this goal in a manner that would minimize patient feelings of being held in detention centre.

> ...they haven't committed any crime, but they are still locked up here. They can't go out and smoke, we understand that..." You listen to them and agree, "We understand it feels like a prison sometimes..." And that is why I am careful... like I don't say 'safety check' or such... It's easier to ask, "Do you have any dishes to wash?" and then I can go in and check a little, collect some mugs and things, talk to them and get a sense of the atmosphere.
>
> (28)

Staff members described how doubt and uncertainty would occur in the care of patients with certain diagnoses, which could affect how nursing staff responded to these patients. Some diagnoses (e.g. depression) were easier to understand and relate to than others. Patients who were more difficult to treat could cause the nursing staff often experienced self-doubt and feelings of inadequacy when encountering difficult to treat patients. Some wards admit patients with different diagnoses, which, according to the staff, place higher demands on them.

> Treating different diagnoses differs a lot because those who are depressed are supposed to be active and come out for fresh air; the anorectics are not allowed to be active and burn calories; the manic [patients]s are not allowed to be stimulated. Hence, it is a difficult balancing act and a tricky group to work with. We are divided in how we work, and in a way, I believe patients see how we distance ourselves, maybe... not inviting particular patients to certain activities.
>
> (16)

Responding to patients with different conditions required the staff to adopt different roles. These roles were either based on a rule-based and firm approach or a gentler and laid-back approach when communicating and spending time with the patients. These staff-related factors could, in the experience of the nursing staff, lead to feelings of frustration and low self-worth. Such feelings could also flare up in situations where another staff member had to assume responsibility for the situation.

3.2 | Nursing is to plan and treat

In this category, attention is centred on the treatment of patients. The nursing staff view their patients as individuals who need to be seen, treated and helped.

Patients are looked upon as fragile and sensitive who need help in their weakest moments. One staff member reported that problems and diagnoses are specific areas to attend to when assessing a patient's current situation. However, to work in a more health-focused way it was also crucial to identify patients' experiences. By building a trustful relationship, a patient's individual needs, capabilities and resources could be identified, which, in turn, should be the basis for planning and facilitating nursing interventions. In the process of building an empathetic and trusting relationship, it is important to always observe patients and act professionally.

> Every second of my work, even if I have a quiet day sitting still and watching TV with two or three patients, or sitting and doing crosswords or something like that, I am always... observing small actions or how something is said. How should I put it... with a professional eye.
>
> (24)

The staff members stated that communication is the most important tool in developing secure and trusting relationships. One staff member said "I found the right way and words so that she [the patient] managed to eat and accept treatment."

(15)

However, as one participant noted, the ability to comprehend the purpose of communication and to use skills in such situations were influenced by the staff's level of education.

Nursing interventions included dialogue, activation, help with basic individual needs, providing a safe environment, psychoeducation, support to establish normal daily routines, optimizing sleep, anxiety relief, simple somatic care, sincere listening and motivating patients to take part in treatment. Feelings of self-blame and worthlessness could surface in situations in which the nursing staff perceived that patients did not have access to care according to plan.

Planning for patients should work but is something that you can't control; it's doctors and... so, plans are made that don't work and the patient suffers, and you feel completely worthless because the patient did not have the opportunity to engage in talks.

(30)

Forcing treatment on patients could be required for those who cannot always make the best decisions for themselves. However, it was emphasized that coercive measures would only be used when necessary and that comply to statutory regulations. Communication between staff members was essential to prevent coercive situations becoming unmanageable.

3.3 | Nursing is to support vulnerable human beings

In this category, emphasis is placed on having awareness and understanding of patients and their needs. Patients are seen as individuals, rather than as members of a group with similar characteristics, with unique backgrounds and in need of individualized care.

A deeper understanding of the patient was considered more helpful than coercive measures and the biomedical approach. Nursing in psychiatric care included making the patients feel important and prioritising their needs. Being able to see the whole person was a prerequisite for attaining the desired level of understanding.

Yes, you try to get to know the person. Who is this? What is his or her background, interests, values, family? What is important? What is the problem this person needs help with? What does this person see as a problem that he or she wants help with?

(22)

Spending time getting to know each patient and building relationships were regarded as important inputs in the process of planning individualized care. Developing a relationship was satisfying and led to a heightened understanding of the patients and their experiences. From this understanding, nursing requires that staff members spend time and work together with the patient.

All patients were seen as individuals with different multifaceted patterns of behaviours. The need for patients to receive attention from the nursing staff was often mentioned. To meet that need an ability to adjust to and deal with different individuals was considered important and required reflection and fingertip feeling (i.e. intuitive knowledge).

(...) Nobody should be forgotten. In the ward I worked in earlier it was those who were heard the most... those who screamed the loudest were helped the most. It can be that way even if they did not have the greatest needs, but they make sure they get help, whereas those who are reticent or circumspect or stay in their rooms are left out, and that is not good nursing.

(34)

Seeing the patients suffer from the side effects of medication could catalyse feelings of helplessness among the staff, as they knew that medical treatment was necessary regardless of the evident side effects.

3.4 | Nursing is to motivate patients

Empowering patients is the main concern of this category. The nursing staff view patients as individuals in need of support, motivation and education on how to combat their mental illness.

The patients' own contribution to and responsibility in the recovery process was seen as a central component of nursing. Having patients take an active role in their care could be achieved through support, information and motivation. In this context one staff member commented, 'But she wanted out. She didn't want to get stuck and she was very motivated... that's what I believe. And we, the staff were very supportive and helped her through the most difficult moments'. (18)

According to the nursing staff, a key point with this understanding is that patients had to learn to accept their situation and embrace their own capabilities.

Yes, and helping them believe in their own capabilities; accepting the real problems they have; learning to see with realistic eyes of the injustices they felt they suffered; learning to communicate with other people when upset and knowing that there are ways to do that; learning to live with the fact that life is not fair; that their situation is much worse than other people's, but to not give up.

(21)

Teamwork was key in helping patients to accept the situation and realise that it was possible to change the way they acted and find ways to deal with their mental illness. Help was delivered in both individual and group settings through different nursing interventions, such as routines, support in hygiene, anxiety management and motivation.

3.5 | Nursing is to have a holistic perspective on the treatment of mental illness

Competence and evidence-based interventions are two core elements of this category. Here, nursing involves treating patients as individuals in need of the best possible care, rehabilitation and emotional security.

Nursing was perceived as a process in which the specialized nurse had a central role. In addition, knowledge in nursing science is important to understand the principles of nursing practice, that is what constitutes safe and effective nursing care. In this understanding the focus centres on 'why' as opposed to 'what', meaning that it was important to understand why the person was feeling or behaving in a certain way instead of focusing on only the observable feeling or behaviour.

Nursing in psychiatric care should be planned with the individual's needs, resources and goals in mind. Nursing is dependent on a supportive and trustful relationship between staff and patients, but it is also dependent on the quality of interactions between nurses and patients.

> We are dealing with people, and because each person is unique, [health] care needs to be unique for each individual. At the same time, we have overreaching general goals; so, it is an art to be able to individualise this... (...) Yes, flexibility (...)... also to critically ask, why am I here? What is the goal? Is this the best? You have to think what is best for this person while at the same time they know what is best for them.
>
> (20)

The staff highlighted that teamwork and coherent descriptions of responsibilities and clear goals for each staff member were central to high-quality nursing. Because treatment could be negatively affected if the staff lacked competence, the skills and abilities of the nursing staff were of paramount importance.

> Spreading competence can be really good, but at the lowest level it can be very, very low when it comes to knowledge regarding what this is about: For example, how to differentiate between breathing difficulties and anxiety? Yes, that is something a person keeping watch should know, etc... I don't always feel good about leaving psychiatric care to all my colleagues, and it is a problem when we discuss specialised psychiatry. It is a problem when my colleagues have to

> ask me "exactly, mania, was that the picture?" ... like "borderline, what does that mean?"
>
> (2)

The nursing staff stated that nursing needed to be based on a mutual belief in a humanistic relationship between people and be shared by all members of the team. They pointed out that a dialogue about such overriding questions should be ongoing and expand the scope to include other health care professionals involved in the care of patients in the wards.

4 | DISCUSSION

Five ways of understanding nursing with focus on the patient, nursing interventions and the goal of nursing in the context of psychiatric inpatient care were identified. We will first discuss the understandings separately and then describe the intricate relationship between them.

Understanding nursing as responding to symptoms and behaviours corresponds to the traditional mindset and medical perspective in today's psychiatric inpatient care (Bladon, 2017; Lakeman & Molloy, 2017). Similar to previous findings, risk management and reactive actions were preferred interventions in this understanding (Mullen, 2009). The phraseology used by the participants objectified the patient – a care climate, well-intended, but influenced by paternalism, analogous to the climate of old mental institutions (Bladon, 2017).

In the understanding of nursing as to plan and treat, treatment was envisioned as the primary aim of care. This understanding is consistent with research aiming at describing the role and function of nurses in psychiatric care in which the main aspects of nursing were limited to managing patients and providing care interventions (Cowman, Farrely, & Gilheany, 2001). Within this understanding, nursing appears to be understood in relation to 'doing'; however, an articulated purpose was not expressed.

Nursing was also understood as supporting vulnerable human beings who have individual needs and preferences. The base for building a relationship was to get to know each patient. A focus on the individual and building trusting relationships is also central in a model for recovery from mental illness (Barker, 2001).

In the understanding of nursing as motivation of patients the patients' responsibility and their own contribution in the process of recovery were noted. These two factors were also underlined by Barker (2001). Empowering patients was used as a nursing strategy, which is in contrast to Deacon and Cleary's (2012) findings showing that nurses did not include empowerment in their definition of recovery. The authors suggested that their results may reflect the perceived role of acute inpatient nurses, who concentrate on only symptom reduction and improvement in functional capacity (Deacon & Cleary, 2012).

The understanding of nursing as having a holistic approach in the treatment of mental illness corresponds to research in which good nursing in psychiatric care has been described as a process with a

clear purpose, attentive to the individual and provided by nurses with specific virtues and personal responsibilities (Gabrielsson et al., 2016; Lakeman, 2012). Applying a structured nursing process according to standards for nursing practice was mentioned in this category, but not in the other categories. This was also the only category in which nursing practice guided by theory was mentioned as a basis for planned interventions.

The outcome space displays a spectrum from limited to more comprehensive understandings. The most comprehensive understanding corresponds to high-quality practice in psychiatric care, based on central aspects of nursing theory and standards (European Federation of Nurses Associations, 2015; International Council of Nurses, 2012; Swedish Association of Psychiatric & Mental Health Nurses, 2014; The Swedish Society of Nursing, 2017). All, except one of the descriptive categories are incorporated as part of the most comprehensive understanding. The categories are differentiated by the way staff members understand the patient, nursing interventions and the goal of nursing. The most limited understanding has no distinct relationship to the other four and we suggest that this can be due to a general lack of knowledge about the nursing process (Henderson, 1982).

Consequently, these results illustrate the vital role of educated nurses with autonomy as overseers of nursing and the nursing process (Paterson, Henderson, & Trivella, 2010). Previous research has identified limited to more comprehensive understandings of how nurses perceive their work (Blomberg et al., 2015; Jangland et al., 2011; Kazimera-Andersson et al., 2015). Variations in understandings of patients and their needs and the professional role of nurses were also found in a meta-synthesis of studies on how health care professionals understand their work (Röing et al., 2018). In contrast to studies with professionally homogenous participants (Röing et al., 2018), the present study included participants with diverse educational levels, which we believe is one reason for the identified differences in the categories (e.g. the way staff members understand the patient, nursing interventions and the goal of nursing). To define nursing in a context where the medical model is the overarching perspective might be difficult for staff members who lack more than basic education in health care and nursing. We suggest that knowledge in nursing as an academic field is a prerequisite to attain more comprehensive understandings of nursing. The different understandings could also be related to the survival of an antiquated culture and maintaining of an old power structure in which nursing as an academic field is not accepted (Lakeman & Molloy, 2017). The limited understanding described in the first category has little or no relation to the vision of good nursing in psychiatric inpatient care of today (Gabrielsson et al., 2016) and has more resemblance to early mental institutions (Bladon, 2017).

Based on our results, it can be assumed that patients admitted to psychiatric inpatient care are likely to meet individual staff members with qualitatively different ways of understanding the patient, nursing interventions and the goal of nursing. Patients have previously reported difficulties to understand the meaning and content of care

in a psychiatric ward setting (Lilja & Hellzén, 2008; Molin et al., 2016; Mullen, 2009). We believe that a shared vision of nursing in psychiatric inpatient care could decrease patients' experiences of confusion and disconnection.

The staff members who represented the most comprehensive understanding embodied a holistic approach guided by nursing theories. Nurse managers should try to identify such staff members, given the importance of developing a shared vision in dialogue with staff who are knowledgeable in both the clinical setting and the literature (Martin et al., 2014a, 2014b). Formation of a shared vision is a management task that distinctively differs from the day-to-day tasks of a nurse manager. Managers have pointed out that developing a shared vision is a process demanding a good deal of time and creative thinking (Martin et al., 2014a, 2014b). Inspiring a shared vision is a leadership practice used by managers at ward levels in hospitals, but thus far has not been prioritized (Silva et al., 2016). Through descriptions from managers in health care, different approaches, which can be systematic or more intuitive, can be used in this process (Martin et al., 2014a, 2014b;).

Based on our results, a shared vision of roles, values and goals was not evident in this sample of nursing staff. A restricted confirmative understanding of roles, values and goals in this clinical context was evident. The professional roles have previously been described as unclear in both somatic (Larsson & Sahlsten, 2016) and psychiatric care (Holmberg et al., 2018). This is problematic when nurses in psychiatric care proclaim that shared values are crucial for good nursing practice (Gabrielsson et al., 2016). In this context Hylén, Kjellin, Pelto-Piri, and Warg (2018) found an association between psychiatric nursing staff's perception of not having similar values at the workplace and problems with stress and bullying. Today, there is sufficient evidence that if nurse managers are able to establish a shared vision of roles, values and goals, a culture that favours quality of nursing can be developed (Martin et al., 2014a, 2014b).

5 | METHODOLOGICAL CONSIDERATIONS

Phenomenography, often used in health science, is seen as a resource to enhance awareness in the context of nursing (Sjöström & Dahlgren, 2002). Concerning the aim of the present study, the choice of phenomenography as the analysis method was deemed appropriate.

Trustworthiness holistically strengthens the outcome and impact of the research (Collier-Reed, Ingerman, & Berglund, 2009). The researchers' knowledge, competence and expertise about the subject of investigation and methodological aspects were merged during the process of planning and conducting the study. The study was thoroughly described and the researchers carried out a transparent discussion throughout the process. Trustworthiness was further achieved through the excerpts provided to support the relevance of the descriptive categories (Sjöström & Dahlgren, 2002).

The results are based on interviews with nursing staff members from a single clinic. Consequently, the results may be affected by the local working culture and organisational factors. The choice of including both NAs and RNs can be a problem when comparing the results with other studies using more homogenous groups.

Because of the character of the chosen design and method, generalising the results to a broader population of nursing personnel should be made carefully (Larsson, 2009). However, transferability to other contexts is up to the reader to determine (Larsson, 2009; Lincoln & Guba, 1985). Psychiatric care has been addressed as a sensitive topic for both patients and staff. An uncertainty about roles and responsibilities (Holmberg et al., 2018) could lead to conflicts of interest between different professions, which might be reflected in the interviews. A few interviews were short and the longest lasted 50 min. The duration may have varied because of differences in experience, knowledge in nursing, level of education and, possibly, attitudes towards nursing and research.

6 | CONCLUSION

The results from this study indicate a variety of ways that the nursing staff in psychiatric inpatient care understand nursing in their clinical work. The understandings varied from limited to more comprehensive and were interrelated based on the perception of the patient, nursing interventions and the goal of nursing. These results further illuminate the challenges in creating a shared vision and direction, as well as defining the roles and responsibilities in nursing (Cleary et al., 2011; Harrison et al., 2017; Martin et al., 2014a, 2014b).

7 | IMPLICATIONS FOR NURSING MANAGEMENT

Nurse managers need to recognize the importance of a shared vision for nursing. This vision has to be given precedence, even though circumstances in the clinical context can impede the visionary work because more acute duties are prioritized. In psychiatric inpatient care there are individuals with different positions in nursing. Although positions are based on education and competence, sometimes commitments are overlapping (Holmberg et al., 2018). In this context, it is even more important that the shared vision includes clear roles, mutual values and goals as a base for a reliable nursing service of good quality (Gabrielsson et al., 2016; Hylén et al., 2018; Martin et al., 2014a, 2014b).

The nursing staff's understandings need to be identified for nurse managers to create a starting point for a long-term process of establishing a shared vision if sustainable high-quality nursing is to be achieved. In addition, nurse managers need to create a working climate where reflections and discussions regarding roles, values and goals are assigned high priority.

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REFERENCES

Barker, P. (2001). The Tidal Model: Developing and empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, *8*, 233–240.

Barnard, A., McCosker, H., & Gerber, R. (1999). Phenomenography: A qualitative research approach for exploring understanding in health care. *Qualitative Health Research*, *9*(2), 212–226. https://doi.org/10.1177/104973299129121794

Bladon, H. (2017). Out of the shadows: De-medicalising mental health nursing. *Mental Health Practice*, *20*(9), 15–20.6. https://doi.org/10.7748/mhp.2017.ell87

Blomberg, A.-C., Bisholt, B., Nilsson, J., & Lindwall, L. (2015). MAking the invisible visible – Operating theatre nurses' perceptions of caring in perioperative practice. *Scandinavian Journal of Caring Science*, *29*, 361–368. https://doi.org/10.1111/scs.12172

Cleary, M., Horsfall, J., Deacon, M., & Jackson, D. (2011). Leadership and mental health nursing. *Issues in Mental Health Nursing*, *32*(10), 632–639. https://doi.org/10.3109/01612840.2011.584362

Collier-Reed, B. I., Ingerman, Å., & Berglund, A. (2009). Reflections on trustworthiness in phenomenographic research: Recognising purpose, context and change in the process of research. *Education as Change*, *13*(2), 339–355. https://doi.org/10.1080/16823200903234901

Cowman, S., Farrely, M., & Gilheany, P. (2001). An examination of the role and function of psychiatric nurses in clinical practice in Ireland. *Journal of Advanced Nursing*, *34*(6), 745–753. https://doi.org/10.1046/j.1365-2648.2001.01804.x

Dahlgren, L., & Fallsberg, M. (1991). Phenomenography as a qualitative approach in social pharmacy research. *Journal of Social and Administrative Pharmacology*, *8*(4), 150–156.

Dall'Alba, G., & Hasselgren, B. (1996). *Reflections on phenomenography – Toward a methodology?*. Gothenburg, Sweden: Acta Universitatis Gothoburgensis.

Deacon, M., & Cleary, M. (2012). The reality of teamwork in an acute mental health ward. *Perspectives in Psychiatric Care*, *49*, 50–57. https://doi.org/10.1111/j.174-6163.2012.00340.x

Delaney, K. R., & Johnson, M. E. (2014). Metasynthesis of research on the role of psychiatric inpatient nurses: What is important to staff? *Journal of the American Psychiatric Nurses Association*, *20*(2), 125. https://doi.org/10.1177/1078390314527551

European Federation of Nurses Associations (2015). *EFN Competency Framework. EFN Guideline to implement Article 31 into national nurses' education programmes*. Brussels, Belgium: European Federation of Nurses Associations.

Gabrielsson, S., Sävenstedt, S., & Olsson, M. (2016). Taking personal responsibility: Nurses' and assistant nurses' experiences of good nursing practice in psychiatric inpatient care. *International Journal of Mental Health Nursing*, *25*, 434–443. https://doi.org/10.1111/inm.12230

Giorgi, A. (1999). A phenomenological perspective on some phenomenographic results on learning. *Journal of Phenomenological Psychology*, *30*(2), 68–93. https://doi.org/10.1163/156916299X00110

Harrison, C. A., Hauck, Y., & Ashby, R. (2017). Breaking down the stigma of mental health nursing: A qualitative study reflecting opinions from western Australian nurses. *Journal of Psychiatric and Mental Health Nursing*, *24*, 513–522. https://doi.org/10.1111/jpm.12392

Henderson, V. (1982). The nursing process – is the title right? *Journal of Advanced Nursing*, *7*(2), 103–109. https://doi.org/10.1111/j.1365-2648.1982.tb00217.x

Holm, A. L., & Severinsson, E. (2010). The role of the mental health nursing leadership. *Journal of Nursing Management*, *18*(4), 463–471. https://doi.org/10.1111/j.1365-2834.2010.01089.x

Holmberg, C., Caro, J., & Sobis, I. (2018). Job satisfaction among Swedish mental health nursing personnel: Revisiting the two-factor theory. *International Journal of Mental Health Nursing*, *27*, 581–592. https://doi.org/10.1111/inm.12339

Hylén, U., Kjellin, L., Pelto-Piri, V., & Warg, L.-E. (2018). Psychosocial work environment within psychiatric inpatient care in Sweden: Violence, stress and value incongruence among nursing staff. *International Journal of Mental Health Nursing*, *27*(3), 1086–1098. https://doi.org/10.1111/inm.12421

International Council of Nurses (2012). *The ICN code of ethics for nurses*. Geneva, Switzerland: International Council of Nurses.

Jangland, E., Larsson, J., & Gunningberg, L. (2011). Surgical nurses' different understandings of their interactions with patients: A phenomenographic study. *Scandinavian Journal of Caring Science*, *25*, 533–541. https://doi.org/10.1111/j.1471-6712.2010.00860.x

Kazimera-Andersson, E., Willman, A., Sjöström-Strand, A., & Borglin, G. (2015). Registered nurses' descriptions of caring: A phenomenographic interview study. *BMC Nursing*, *14*, 16. https://doi.org/10.1186/s12912-015-0067-9

Lakeman, R. (2012). What is good mental health nursing? A survey of Irish nurses. *Archives of Psychiatric Nursing*, *26*(3), 225–231. https://doi.org/10.1016/j.apnu.2011.10.005

Lakeman, R., & Molloy, L. (2017). Rise of the zombie institution, the failure of mental health nursing leadership, and mental health nursing as a zombie category. *International Journal of Mental Health Nursing*, *27*(3), 1009–1014. https://doi.org/10.1111/inm.12408

Larsson, I. E., & Sahlsten, M. J. M. (2016). The staff nurse clinical leader at the bedside: Swedish registered nurses' perceptions. *Nursing Research and Practice*, *2016*, 1–8. https://doi.org/10.1155/2016/1797014

Larsson, S. (2009). A pluralist view of generalization in qualitative research. *International Journal of Research & Method in Education*, *32*(1), 25–38. https://doi.org/10.1080/17437270902759931

Lilja, L., & Hellzén, O. (2008). Former patients' experiences of psychiatric care: A qualitative investigation. *International Journal of Mental Health Nursing*, *17*, 279–286. https://doi.org/10.1111/j.1447-0349.2008.00544.x

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: SAGE Publications Inc.

Martin, J., McCormack, B., Fitzsimons, D., & Spirig, R. (2014a). Evaluation of leadership practices: How to develop a vision. *Journal of Research in Nursing*, *19*(2), 102–115. https://doi.org/10.1177/1744987114523977

Martin, J., McCormack, B., Fitzsimons, D., & Spirig, R. (2014b). The importance of inspiring a shared vision. *International Practice Development Journal*, *4*(2) [4]. http://www.fons.org/library/journal.aspx

Marton, F. (1981). Phenomenography – Describing conceptions of the world around us. *Instructional Science*, *10*(2), 177–200. https://doi.org/10.1007/BF00132516

Marton, F., & Booth, S.. (1997). *Learning and awareness*. Mahwah, NJ: Lawrence Erlbaum Associates.

Mission Mental Health (2018). *Vuxenpsykiatrin i siffror 2017 - Vuxenpsykiatri* (in Swedish). Kartläggning 2018.

Molin, J., Graneheim, U. H., & Lindgren, B.-M. (2016). Quality of interactions influence everyday life in psychiatric inpatient care -patients' perspectives. *International Journal of Qualitative Studies on Health and Well-being*, *11*(1), 29897. https://doi.org/10.3402/ghw.v11.29897

Mrayyan, M. T. (2004). Nurses' autonomy: Influence of nurse managers' actions. *Journal of Advanced Nursing*, *45*(3), 326–336. https://doi.org/10.1046/j.1365-2648.2003.02893.x

Mullen, A. (2009). Mental health nurses establishing psychosocial interventions within acute inpatient settings. *International Journal of Mental Health Nursing*, *18*, 83–90. https://doi.org/10.1111/j.1447-0349.2008.00578.x

Paterson, K., Henderson, A., & Trivella, A. (2010). Educating for leadership: A programme designed to build a responsive health care culture. *Journal of Nursing Management*, *18*(1), 78–83. https://doi.org/10.1111/j.1365-2834.2009.01065.x

Röing, M., Holmström, I., & Larsson, J. (2018). A metasynthesis of phenomenographic articles on understandings of work among healthcare professionals. *Qualitative Health Research*, *28*(2), 273–291. https://doi.org/10.1177./1049732317719433

Silva, V. L., Camelo, S. H., Soares, M. I., Resck, Z. M., Chaves, L. D., Santos, F. C., & Leal, L. A. (2016). Leadership practices in hospital nursing: a self of manager nurses. *Revista Da Escola De Enfermagem*, *51*, e03206. https://doi.org/10.1590/S1980-220X20160995032 06

Sjöström, B., & Dahlgren, L. O. (2002). Applying phenomenography in nursing research. *Nursing Theory and Concept Development or Analysis*, *40*(3), 339–345. https://doi.org/10.1046/j.1365-2648.2002.02375.x

Swedish Association of Psychiatric and Mental Health Nurses (2014). *Kompetensbeskrivning för legitimerad sjuksköterska med specialistsjuksköterskeexamen, inriktning psykiatrisk vård* (in Swedish).

The Swedish Society of Nursing (2017). *Kompetensbeskrivning för legitimerad sjuksköterska* (in Swedish).

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042