Psychiatric Patients’ Perceptions of Constant Care

Constant care (CC), constant observation, suicide watch, specializing, maximum observation, and one-on-one care are terms used to describe the constant presence of a caregiver with a patient (Cardell & Pitula, 1999; Duffy, 1995; Fletcher, 1999; Moore, Berman, & Knight, 1995). Constant care is a common intervention used in psychiatric services, but it also is used in other health care services (Worley, Gitlin, & Conway, 2000). Providers of this level of care include:

- Sitters.
- Volunteers.
- Security guards.
- Family members.
- Non-nursing staff.
- Nursing staff.

Researchers using survey methods have established that CC is a costly intervention (Blumenfield, Milazzo, & Orlowski, 2000; Moore et al., 1995; Worley et al., 2000) that requires health care providers to establish policies and protocols to ensure the judicious assignment of CC. For example, after surveying 102 medical-surgical hospitals, Worley et al. (2000) suggested costs for CC could be contained if patients were relocated to an environment that allows observation of more than one patient by a staff member; less costly care providers, such as volunteers, were used; and family members were asked to help pay the cost of CC. They also recommended a preventive approach, which included educating the staff in the areas of the cost of CC, better overall assessment of patients, and providing patients with aids for self-care (Worley et al., 2000).

Given the wide use and costs of CC, it is important to ascertain the effectiveness of this intervention. The author pondered what it would be like to be admitted to a psychiatric unit and have a nurse, security guard, or family member continuously, and at times relentlessly, watching her while she was in the bathroom, eating, sleeping, having visitors, smoking in the smoking room, or simply sitting in her assigned room. As a nurse providing CC, the author thought this intervention must have a profound effect on the patient. To determine this effect, only patients who had experienced CC could describe what it was like for them. Therefore, the purpose of this research study was to discover the meaning, value, and experience of CC from patients’ perspectives.
LITERATURE REVIEW

Qualitative methods were used to obtain data from patients who had received CC, and it was discovered that patients perceived staff as either therapeutic or nontherapeutic (Cardell & Pitula, 1999; Müller & Poggenpoel, 1996; Pitula & Cardell, 1996). Therapeutic staff behaviors included:

- Providing safety, support, and distractions.
- Promoting hope.
- Acknowledging patients.

Nontherapeutic staff behaviors included:

- Lacking empathy and caring.
- Not respecting privacy or space.
- Stereotyping.
- Enforcing rules.
- Not providing information about the reasons for CC.

Using ethnography methods of participant observation and interviewing, Fletcher (1999) collected data on patients and staff and found two purposes for CC emerged:

- Control.
- Therapeutic endeavors.

Negative behaviors were generated in patients by staff who were controlling, while positive feelings were facilitated by staff who understood and accepted patients. Using another approach and completing the first research study in this area, Briggs (1974) submitted an author-generated questionnaire to patients and found they viewed CC as negative, custodial, and used for punitive reasons. Jones, Lowe, and Ward (2000) and Jones, Ward, Wellman, Hall, and Lowe (2000) researched primary close observation in which only one patient received CC in both studies. Similar to Briggs, they also found the experience was negative for the patient, but the relationship formed between the nurse and patient was significant.

Focusing only on provisions of CC, Duffy (1995) used a grounded theory approach to interview 10 staff members. The author found

METHOD

The research questions included:

- What does CC mean to you?
- How does CC affect your relationship with the nurse?
- What is the purpose and value of CC?

A qualitative method was chosen to collect and analyze the data because of the need to understand and describe CC. When using qualitative methods, it is assumed data will include rich descriptions of events, persons, situations, or behaviors; the setting will be naturalistic; the data will have an orientation toward process and phenomena; and participants (i.e., patients) will be able and willing to describe the phenomena being studied (Benoliel, 1984; Glaser & Strauss, 1981; Leininger, 1985).

Definitions

Constant care was defined as the provision of continuous nursing attendance and observation of a patient. Staff members are assigned to be with a patient at all times and will not have other assigned duties. Patients were assigned constant care because they were considered a danger to themselves. At times, patients received CC if they were considered a danger to others. The providers of CC in this study were all psychiatric registered nurses.

Sample

Patients were nominated to be included in the study by staff members, psychiatrists, and administrators after the researcher facilitated an educational session about the nature of the research project. Eight acute care psychiatric patients (Table 1), who agreed to sign a consent form to be interviewed, from three different units in one hospital comprised the study sample. The patients met the criteria of having received a minimum of nine, 8-hour CC shifts.
Patients were coherent, nonviolent, articulate, and older than the age of 18. Patients were interviewed as soon as possible after being released from CC. Data were saturated after 8 patients were interviewed.

**Data Collection**

Each patient was approached at least three times. Initially, they were told about the project, what was expected of them, the type of questions they would be asked, and the implications of signing a consent. In the second meeting, each patient was interviewed in an office on the unit using a semi-structured format (Table 2). The interview questions were reviewed prior to use by a panel of four psychiatric nurses for clarity and content. Each interview was audiotape recorded and transcribed and then given back, when possible, to the patients for verification. The interviews were intensive and averaged 1½ hours.

**Reliability and Validity**

To increase reliability, participants were asked to verify the data after the tapes of the interviews had been transcribed. A peer, not associated with psychiatric nursing, reviewed the raw data to identify themes, which were matched against the researcher’s findings.

Validity was high in this study because the researcher herself conducted the interviews, and the stories the participants told were accepted as their reality (Bruyn, 1966). To guard against bias and a halo effect, the researcher presented herself as a researcher and not a nurse. It was assumed patients would feel safer disclosing sensitive material to someone external to the nursing unit.

**Ethical Considerations**

The study received ethical approval from the joint university and hospital ethics committee.

Four ethical issues had to be addressed (Rose, 1986; Sudman & Bradburn, 1985):

- Right to privacy.
- Informed consent.
- Confidentiality.
- Competency.

Because of these ethical concerns, patients were approached about participating after CC was discontinued, interviews with the patients were conducted in an office adjacent to the unit, and permission to interview the patients was obtained from the unit staff and patients.

**FINDINGS**

The patients who experienced CC were extremely articulate about the nursing care they received because of the staff’s nomination process to determine who would be willing and able to speak about their experiences. The patients noted more than 50 specific nursing actions perceived to be helpful, including advantages of CC in the areas of feeling safer, increasing confidence, and having extra care, as well as negative experiences with certain nurses and situations. The nursing behaviors the patients identified can be grouped under the themes of providing structure, communicating respect, teaching specific skills, therapeutic behaviors, nontherapeutic behaviors, specific behaviors of nurses, and personal preference of patients.

**Providing Structure**

Structure had two dimensions. In the first, the nurse purposefully structured the patient by facilitating patient activities, such as playing cards. In the second dimension, the nurse provided structure by being there and involving the patients in what they were doing, such as telling them about their knitting. This finding is similar to

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**TABLE 1**

<table>
<thead>
<tr>
<th>Patients</th>
<th>Diagnosis at Admission</th>
<th>N</th>
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<tbody>
<tr>
<td><strong>Women</strong></td>
<td>Anorexia</td>
<td>1</td>
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<td></td>
<td>Bulimia</td>
<td>1</td>
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<td>Depression</td>
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<td></td>
<td>Manic depression</td>
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<td></td>
<td>Schizophrenia</td>
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<td></td>
<td>Organic brain syndrome</td>
<td>1</td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td>Alcoholism</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
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what Cardell and Pitula (1999) termed as distraction.

The nurses also would try to structure the patients' future by insisting the patients make plans for the next shift. The patients applauded nurses who made them focus on positive emotions. This was accomplished by nurses giving the patients a homework assignment that consisted of having them recall five positive events or write down one goal per shift to enhance positive feelings. Through provision of dimensional activities, all patients were forced to concentrate and thus did not dwell on negative thoughts.

**Communicating Respect**

Respect for patients from the nurses was demonstrated when patients were asked their opinions, involved in decisions, informed of the nurses' routines, redirected to focus on the topic during patient-nurse interactions, and given realistic tasks. Patients appreciated nurses who asked them what they were going to do that shift to make themselves feel better. They also liked nurses who made them reflect on their abilities versus their weaknesses. The nurses who made eye contact, remembered patients' names, offered hope but did not give advice, and communicated an attitude that they were "for the patient" increased patients' feelings of self-worth. This finding also was reported by Cardell and Pitula (1999), who stated patients appreciated being acknowledged, and by Fletcher (1999), who reported patients felt better knowing that they were not being judged.

**Teaching Specific Skills**

Patients believed the nurses taught them skills. They felt they received specific skills in the areas of:

- Stress management (e.g., self-talk, relaxation tapes).
- Problem solving (e.g., "what if?").
- Health teaching regarding relationships, medications, and illnesses (e.g., regaining control over thoughts and feelings, decreasing hallucinations).
- Communication skills (e.g., using "I" statements, reframing events, speaking with family members, pacing interactions).

When nurses were viewed as "normal," patients viewed them as role models and credible teachers, particularly if they were the same gender as the nurses. This finding was supported by Jones, Lowe, et al. (2000), but differed from the patients interviewed by Fletcher (1999). In the latter study, patients complained they did not receive explanations or teaching from the staff. The difference in findings could be related to the particular philosophy of the staff in this study. Because the setting was a teaching hospital, students from all disciplines were welcomed and health teaching for patients was expected.

**Therapeutic Behaviors**

Caring was recognized by all 8 patients when the nurse disclosed personal information to them, such as why he or she liked nursing, what had been accomplished on days off from work, or what activity was planned for after work. Nurses often shared apples with patients or brought in reading material and even old clothing for
the patients. The nurses' attitudes were key factors, as illustrated in the following quote from a patient:

She communicated to me that she was proud of me, eager to help, sincere, not embarrassed by having to be with a psychiatric patient, offered total acceptance, showed no biases, and made me feel I was a priority.

Patients recognized their illnesses were difficult for nurses and appreciated when nurses tolerated their need to constantly repeat the same thing, such as getting drinks from the water fountain. Patients also appreciated nurses withholding negative feelings that likely were present, as well as providing a safe environment by positioning themselves between the door or railing to prevent patient injury or self-harm. When nurses administered physical care, such as changing the bed, washing hair, helping patients walk when their legs felt shaky, or mobilizing patients to perform self-care, the patients felt the nurses cared for them. Jones, Lowe, et al. (2000) also found patients wanted to have an interactive relationship with nurses.

When the nurses radiated positive feelings, treated the patients as they would treat a friend, anticipated what the patients intended to do, or gave the patients immediate feedback, the nurses were distinguished from other nurses. Some patients appreciated nurses who were nice to their roommates and those who encouraged roommates to talk to and do things with the patient receiving CC. Including family members when nurses performed assessments was viewed as a positive experience for patients. A few patients commented on the personalities of the nurses. Helpful nurses were described as quiet, calm, kind, involved, agreeable, comfortable, and understanding. Nurses who could forgive patients were valued because, as one patient said, “I have a hard enough time forgiving myself.”

**Nontherapeutic Behaviors of Nurses**

The negative aspects of CC included references to the bathroom, lack of privacy, lack of continuity, and specific behaviors of a few nurses. Receiving CC while in the bathroom irritated most of the patients because they believed nurses assumed they would hurt themselves. Cardell and Pitula (1999) also observed that patients receiving CC resented a lack of privacy, viewing CC as an invasion of their personal space. Staff were inconsistent about actually being in the bathroom, and the patients felt tense not knowing what staff members were going to do. One patient would go to the bathroom only on shifts where she was assured the nurse would not be with her.

A lack of privacy was expressed by the patients in terms of being stared at, CC nurses staying while patients talked with visitors, nurses watching them eat, and feeling uncomfortable with being someone awake in the room when they were trying to sleep. The problem with lack of continuity was described by patients in terms of experiencing irritation when replacement staff asked too many questions, frustration when patients were requested to explain their illness to “new” nurses, and anxiety as to what the new nurses would be like.

**Specific Behaviors of Nurses**

A few nurses acted in a manner that angered patients. One nurse “dragged the patient around” and made the patient sit by the telephone so she could make personal telephone calls. The same nurse was described by a patient:

She's really moody. She gave the janitor hell, gave the lady in the store downstairs hell. She's not right for a psych ward. Just keep her away from here. Every time I run into her, we just look away. But I remember telling my girlfriend that I felt so bad about it.

When this nurse was responsible for CC with another patient, the patient said, “She read the paper all day.” As a result of this behavior, the patient had to initiate all nursing activities. When the evening nurse arrived, the patient was so relieved she became “manic with joy.”

Another patient had a nurse who “never spoke a word for the whole 8 hours.” His response to this was quite marked as shown in the following quotes:

- I got more and more and more depressed. I just lay on my bed and closed my eyes for the whole 8 hours. I didn't want to have anything to do with them. I didn't know what else to do.
- It was worse than having nobody there. I lay down, hid my face. I didn't even want to sit up and read because I had to look at her. And maybe I'd have to think of something to say to her, and the
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ticularly difficult for nurses and patients when it is not really required. This situation meant patients felt they had to entertain nurses.

**Personal Preference of Patients**

The patients had strong personal preferences for certain nurses. One patient wanted a nurse who she could express her feelings to, one who really understood her and who respected her privacy by charting while she ate. If the patient did not have this type of nurse, she would “punish the nurse by acting out.” Other patients described their personal preferences as:

- It depends who actually happens to be on constant with you. Some of them you really despise, and others you sit there and talk with and have a great

You don’t pick, so depending on who you happen to get really makes a difference as to whether it’s shut up and leave me alone or, you know, okay, let’s talk or something.

- I grew to like certain nurses, and hate certain nurses...some of them, like, they’re kinder, they kind of understand, they know you from before so they understand the way you’re reacting. And they’re quieter and calmer. Maybe because I know them and I like them, I try and behave more than when it’s somebody sitting there that I actually don’t like ‘cause then it’s like, I really don’t want you around, get away from me.

**DISCUSSION**

The patients proved to be good informants of their experiences with CC. They could identify specific helpful and nonhelpful nursing actions. They recognized that they felt scattered and disorganized, so they wanted a nurse who was “together.” The comments about the nurses’ personalities were interesting because the patients did not discriminate between the personality of the nurses and their skills. The nurses’ presence, and what they were like as people, was important to the patients, whereas their skills were assumed to be “just there” because they were labeled as nurses. This finding was confirmed by Gijbels (1995) who found that one role of nurses is “being there”... over a 24-hour period” (p. 461).

The observations about the moody and silent nurses were disturbing findings. When nurses behave in such a manner, they are emotionally abusing patients. Fletcher (1999) also found that if care providers sat in silence, this was perceived as hostile by patients. Nurses may not realize they are having such a profound effect on patients. Unfortunately, psychiatric patients’ complaints about staff are not always viewed as credible because negativity and agitation are part of many psychiatric illnesses. However, it behooves nursing staff to examine the difference between patient-generated versus nurse-generated negativism.

Patients’ observations about personal preferences, multiple nurses, and difficulties with privacy stem from a lack of intimate nurse-patient relationships. Peplau (1952) discussed this issue when she noted the need for intimacy between nurses and patients. Without intimacy, she contended there could be no focus on positive feelings (Peplau, 1952). If nurses don’t know patients, they are strangers. Strangers violate privacy, ask too many questions, and have to prove themselves before they will be trusted. Assignment of nurses to patients requiring CC should be based on fostering a nurse-patient relationship (i.e., not assigning temporary staff), pairing nurses and patients who have a general affinity for each other, and assigning nurses of the same gender as patients.

Nurses’ ability to normalize patients’ experiences was a recurrent theme. If nurses disclosed what their personal lives were like, patients had vicarious contact with the world outside of the hospital and thus the care giving for them became a role model of normalcy. Nurses working in psychiatry have a general reluctance to disclose per-
sonal information to patients because the information may be misinterpreted or used inappropriately. Nevertheless, there needs to be more disclosure of ordinary and public events, which, to a nurse, may not seem worth commenting on, such as telling patients about the evening news. Cohen (1994) alluded to this in her case study when she described psychiatric hospitalization in a locked unit as isolating and terrifying for patients. Nurses need to be sensitive to how patients may perceive hospitalization and remember that hospitalization is part of a process whereby patients must be prepared to enter public life.

Limitations to this study include the small sample size and the data being collected from one institution. The findings cannot be generalized to other psychiatric settings. Because the researcher could not directly access the patients and they were nominated by staff, a pool of professionals applied the selection criteria, which resulted in variability.

CONCLUSION

The findings of this study and how the impact of nursing care was reflected in the descriptions of structuring patient activities, sharing respect, teaching therapeutic behaviors, and analyzing valid research conducted by Cardell and Pitula (1999) and Fletcher (1999) demonstrate the therapeutic effectiveness of this intervention. When CC duty is given to a security guard, there is an expectation of guarding. To expect the interventions of structuring activities and teaching from a nonprofessional caregiver, such as a security guard, would be entirely unreasonable. Furthermore, it may even be argued that novice psychiatric nurses may have difficulty being effective when providing CC. Patients receiving CC rarely give direct verbal feedback to nurses about interventions, and it is not their role to teach nurses. Through teachings by experienced nurses and reviewing of research literature, novice nurses can best acquire the skills for research-based practice in this area.

What was noteworthy about this study is how insightful the patients were about the CC experience. Furthermore, data from their interviews provided an extensive description of therapeutic nursing care behaviors. Through research of patients' experiences about CC, an expected standard of care can be explored.

Finally, this study has implications for policy development and review. Policies pertaining to CC need to refer to when it should be initiated, how it should be administered, and the purpose and intended outcomes. The findings in the areas of structure, respect, and teaching show the merit of using CC, whereas the finding of nontherapeutic behavior provides a case of not using CC.

REFERENCES


Dr. Yonge is Professor, Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada. Address correspondence to Olive Yonge, RN, PhD, CPych, Professor, Faculty of Nursing, University of Alberta, Edmonton, Alberta T6G 2G3, Canada; e-mail: olive.yonge@ualberta.ca.