

How patients and nurses experience an open versus enclosed nursing station on an inpatient psychiatric unit

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Abstract:

The inpatient environment is a critical space for nurses and patients in psychiatric settings. In this article, we describe nurses' and patients' perceptions of the inpatient environment both before the removal of a Plexiglas enclosure around a nurses' station and after its removal. Nurses had mixed feelings about the enclosure, reporting that it provided for confidentiality and a concentrated work space but also acknowledged the challenge of the barrier for communication with their patients. Patients unanimously preferred the nurses' station without the barrier, reporting increased feelings of freedom, safety, and connection with the nurses after its removal. It is important to consider the implications of environmental decisions in inpatient settings in order to promote a healthy workplace and healing environment for all community members.

Keywords: psychiatric nursing | inpatient psychiatric nursing | acute care | mental health nursing | nursing station | nurse-patient relationship | engagement | unit safety | environment of care

Article:

Persons with mental illness may experience inpatient hospitalization at some point in their lives (Anderson, Huff, & Hodgson, 2008). The environment of an inpatient psychiatric setting is a key aspect of treatment for those hospitalized in these settings. Understanding how the environment affects patients and understanding important aspects of the environment that facilitate feelings of safety and self-control are important for designing the physical space of an inpatient unit. In addition, this knowledge is important for structuring an interpersonal environment that fosters health and healing among hospitalized patients. Although some research has been conducted in inpatient units, "environment" has been defined in various ways. Several studies have examined the interpersonal environment of people who work on inpatient psychiatric units and the level of support mental health nurses receive from administrators or physicians (Hanrahn, Aiken, McClaine, & Hanlon, 2010; Hinnö, Partanen, Vhvilainen-Julkunen, & Aaviksoo, 2009). Others

have studied the structural environment, the physical appearance of the psychiatric unit, and the nurses' station (Tyson, Lambert, & Beattie, 2002); some researchers have studied both the interpersonal and structural environments in inpatient psychiatric settings (Andes & Shattell, 2006; Kontio et al., 2014; Shattell, Andes, & Thomas, 2008), but few have looked at the structural and interpersonal environment where much of "nursing work" is done—the nurses' station.

The nursing station is often considered "patient-free" (McMahon, 1994). Nursing stations with glass partitions limit patient access to staff members (Schweitzer, Gilpin, & Frampton, 2004) and may reinforce the importance of boundaries in the psychiatric unit, and promote confidentiality of patient information. However, glass partitions subtly suggest that patients cannot respect the nursing station as a work area and need to be physically barred (Shattell et al., 2008). The psychiatric environment should be conducive to recovery, and it should function to help patients (Shrivastava, Kumar, & Jacobson, 1999) achieve their optimum level of wellness. Johnson and Delaney (2006) suggest that a key component of a safe inpatient psychiatric environment is the space of the unit. Visibility and proximity of staff to patients contribute to patients' feelings of safety; however, Johnson and Delaney (2006) also found that having locked doors on nursing stations promoted boundaries for patients that also contributed to safety, and therefore was a positive aspect of the environment. To better care for patients hospitalized on acute care psychiatric units, The Joint Commission has recommended reconstruction of nursing stations in order to better allow staff to see, hear, and attend to their patients' needs (Southard et al., 2012).

A previous study conducted on the same adult inpatient psychiatric unit examined in this study looked at how patients and staff members experienced the unit (Shattell et al., 2008). Using a phenomenological approach, they found that patients hospitalized in this unit reported feelings of powerlessness and lack of control over their environment. They felt intimidated by the unit rules. Nurses also felt intimidated, through a perceived disconnect between the nurses and the unit's and hospital's leadership. Both nurses and patients questioned the ability of the hospital to help patients. The authors recommended the removal of physical barriers such as the Plexiglas enclosure around the nursing station in order to facilitate patient and staff interactions. Based on that study, the enclosed nursing station in the adult unit at the study hospital was converted to an open nursing station where patients could have easier access to their nurses and other staff members (Southard et al., 2012). Anecdotal reports from patients and nurses during data collection in the quantitative study revealed questions about how these individuals experienced the nursing station (Southard et al., 2012). No studies could be found that addressed how patients and nurses reacted to an open versus an enclosed nursing station in an acute care psychiatric unit. Therefore, the current study examined the experience of an open nurses' station from the perspective of both patients and nurses who had experienced the unit when the nursing station was enclosed.

Method

Study Design and Setting

A qualitative design with an existential phenomenological approach was used in this study. Existential phenomenology was chosen because we were interested in the individual experience

of the open and enclosed nursing station in an adult acute psychiatric unit. The practice of existential phenomenology involves engagement with human concerns. By approaching subjects phenomenologically, we focus on the obvious, exposed by the situation in the moment—grasping what is and meeting the participant within his or her environment, without preconception or speculations (Shattell et al., 2014). Through this qualitative study, we sought to better understand the experience of those who spend time in and around the nursing station.

The setting was a 48-bed inpatient adult psychiatric unit in a freestanding, acute psychiatric hospital in southeastern United States. The nursing station in this unit is centrally located and prior to September 2010 was entirely enclosed with antishatter tempered glass (Southard et al., 2012). There was a small window in the middle of the station, which a patient service coordinator (unit secretary) would open in order to respond to patients. After the renovation, the nursing station's glass enclosure was removed and nurses' and assistive personnel's work areas were moved to the front of the station. The patient service coordinator's area was moved to the back of the station. The square footage of the nursing station did not change.

Sample

The inclusion criteria for patients were the following: (1) admitted on the unit when the nursing station was enclosed (prior to September 2010) and again after it was opened in October 2011, (2) hospitalization for at least 2.5 days during each admission, (3) being judged as mentally competent, (4) at least 18 years of age, and (5) English-speaking. Electronic medical records were used to confirm the patients' admissions to the unit. Patients experiencing psychotic symptoms were excluded. The inclusion criteria for nurses were the following: those presently working in the unit and also employed prior to September 2010 when the nursing station was enclosed. We sought a sample size of at least 12 persons per group (12 patients and 12 nurses) as this has been found to be an adequate sample size to establish variability and data saturation (Guest, Bunce, & Johnson, 2006).

Data Collection and Procedures

The study was approved by the hospital and university institutional review boards. One of the researchers reviewed the daily patient census list and then checked the electronic medical records for each new admission to determine if the patient had been an inpatient in the unit when the nursing station was enclosed. A researcher would then meet with the patient's assigned nurses to determine if the patient spoke English and was not psychotic. If the patient spoke English and was not psychotic, the researcher would approach him or her about the study. For registered nurse (RN) participants, a researcher met with the unit director who gave a list of all RNs who were hired prior to the time when the nursing station was opened. Data were not collected on the number of potential patient and nurse participants who declined to participate. The reasons for declining participation were not documented. Anecdotally, however, we can say that many potential patient participants declined because they said they could not remember what the nursing station was like when it was enclosed. Most nurses approached agreed to participate. Written informed consent was obtained from each participant prior to data collection. Participants were not compensated for their participation in the study.

Open-ended phenomenological interviews were conducted with nurses and patients in 2013, which was approximately 2.5 years after the enclosure had been removed. The time lag for this study was because the study was not designed a priori to the changes in the nursing station design but came from questions derived from a quantitative study that sought to measure change in milieu (Southard et al., 2012). Patient participants were interviewed during their hospitalization. Participants were asked, “Tell me about a time when you were aware of the open nursing station or enclosed nursing station.” This opening question allowed for participants to fully describe their experience without limitations. Follow-up questions were used to clarify participants’ statements. Interviews took place on the unit in a private location. They were digitally audio recorded and transcribed verbatim. Demographic information was also obtained from the participants.

Data Analysis

The interview data were analyzed using the existential phenomenological method described by Pollio, Henley, and Thompson (1997) and Thomas and Pollio (2002). Interviews were transcribed and read in the order in which they occurred. Researchers analyzed each transcript for meaning units and moved from the meaning units to the entire transcript. An initial structure of the experience of each participant was developed, and then a structure of the experience for each group (patients and nurses) was developed. The researchers then developed an overall structure of the experience that was presented to two staff participants (we were unable to locate patient participants). Feedback from these participants helped us clarify the themes. All transcripts were reread to finalize the thematic structure. Demographic data from participants were analyzed using mean, mode, ranges, and frequency distributions.

Findings

Demographics

The sample included 29 persons—13 patients and 16 RN staff members. Patient participants included 3 women and 10 men; 5 of these identified as Black/African American, 7 as Caucasian, and 1 as “other.” Self-reported diagnoses included depression ($n = 6$), bipolar disorder ($n = 6$), substance abuse ($n = 8$), and schizophrenia ($n = 1$); one participant reported issues with “cutting,” one identified as having “suicidal ideation,” and another identified “suicide attempt.” Most patients reported multiple diagnoses. The education levels of patients varied: Some had earned their diploma/GED ($n = 5$); others reported having completed some college ($n = 4$); two identified as having an education level lower than high school; one had an associate’s degree; and another had a bachelor’s degree. The majority of patient participants were not currently employed ($n = 10$); only two worked full time, and one worked part-time.

In the all-RN staff sample, 15 were female and 1 was male; 14 identified as Caucasian, and 2 identified as Black/African American. Seven staff members had earned a bachelor’s degree; 4 had received an associate’s degree; 3 held master’s degrees, and 2 had earned nursing diplomas. The minimum amount of time a staff member had worked on the unit was 4 years, while the maximum amount was 15 years; the average number of years worked on the unit was 8.9 years ($SD = 4.18$). The minimum amount of psychiatric experience the staff members had was 4 years,

while the maximum was 25 years; the average number of years of psychiatric experience was 13.95 years ($SD = 7.6$).

Themes

The open design of the nurses' station initiated a change in the meaning of space for nurses and patients. The removal of the glass barrier created for some nurses a greater sense of awareness but for others a feeling that the nurses' station should remain a "nurse-only" space. The themes that emerged from the nurses' experiences were confidentiality, awareness, and communication strengths and weaknesses. Patient participants experienced freedom and togetherness.

Nurses' Experiences

Confidentiality. The primary concern of all of the nurse participants was that of confidentiality. One nurse believed that it was easier to violate the Health Insurance Portability and Accountability Act (HIPAA; Federal Register, 2013) after removal of the glass barrier: "That's something that really, really concerns me. And my coworkers, we all try to respect HIPAA rules and regulations that cover our patients here. And I think often it gets by us." For some nurses, patients overhearing confidential patient information was inevitable: "It's human nature to kind of hang out and want to know what's going on . . . If I were in the same spot as the patient, I might be hanging out at the nurses' desk." One nurse said that patients would sit below the desk out of eyesight of nurses conversing at the station. Nurses said that some patients who had overheard nurses' conversations had taken things said at the station out of context and that this had created tension and anxiety on the unit: "I think there's a privacy issue that the patients can often hear and lock into a conversation, and then take one piece of that conversation at the station and relay it to another patient. It can stir up anxiety." Some nurses experienced patients questioning what patients had overheard at the station:

I had a patient . . . walk up and quote some of the conversation that had happened with the staff behind that nurses' desk about our new leadership and the new rules surrounding snacks . . . and it was awkward. What do I do? Slap them on the hand and say "Oh, bad girl. You weren't supposed to be listening. That's none of your business?"

Although some nurses may have experienced incidents where conversations were overheard at the station, one nurse felt that removal of the glass enclosure encouraged the staff at the nurses' station to be more conscious. One said that removal of the glass barrier cut down on unnecessary discussion at the station and furthermore, the glass enclosure may not have been HIPAA-proof: "They're feeling like it's confidential and HIPAA safe. I can hear them. The patient is going to hear them." According to one nurse participant, it might be "tricky" to find an area to discuss confidential matters and require extra maneuvering to avoid being overheard, but it was not impossible to adhere to HIPAA requirements.

However, one nurse commented that confidentiality was the dominant issue after the renovation: "I think a lot of the nurses don't particularly care for it being down. They like being able to be more private and not have to worry about patient confidentiality as much as with it being up."

Awareness. While the open design brought questions of preserving patient confidentiality, it also invited better methods of observing the unit milieu. One nurse noted the benefits of being more physically present at the station:

They can physically see me and talk to me even if I'm sitting at the computer. They can get my attention. And once they get my attention, I'm right there talking to them. Even if sometimes there is the counter between us, there is still that interaction in that closeness.

One nurse recalled a situation where the open station enabled the staff to deescalate patients:

I could hear them every time that they were out in the hall. And if they came up to the desk, I could respond to their needs immediately. We were near CIRTs [crisis intervention resolution techniques] a couple of times. But because the staff was right there, and able to respond immediately, we were able to verbally interact, and we didn't have to lay hands on. We didn't have to call for any backup. We were OK. If that glass was up, and we weren't there responding immediately to those patients' needs, I think it would have been a lot worse.

According to some nurses, the open station allowed for patients' needs to be met more efficiently. As one nurse noted, "I kind of liked the fact that it was open and we were more responsive to patients. You know, they were right there." Some nurses said that they liked knowing what their patients' needs were personally, instead of having a patient service coordinator act as a "middleman":

I don't mind somebody coming up and asking to speak to me in the nurses' station. That's never bothered me. I'd rather go ahead and find out what they want and try to fulfill their needs, and then go on with the next task that I need to do.

Communication strengths and weaknesses. Some nurses believed that the glass enclosure was impersonal and a barrier to communicating with their patients. The glass enclosure created a sense for the patients that the station was off-limits and that the nursing staff did not want to be close to the patients. It may have also prevented the patients from openly communicating with the nurses. According to one nurse,

It just makes you feel like that you're separated from them, like it's really impersonal and it just seems to me like they [nurses] looked at you [patients] like you're different. Or they don't want to be near you . . . But I would think as a patient, that I would feel like they don't really want to provide me with any kind of care. That way they want to separate themselves. I would think, "Well, they're probably just talking up there. They're probably not working or doing anything." So, just from a patient point of view, I could see that. I kind of felt that way, too. It's like, golly; this is kind of closed off. I'm closed off from my patients, you know?

One nurse felt that it elevated patient frustration:

Because some people will just stand around and think, “Oh, I must be in the way. They must be busy. I don’t see them. They must not want me up here right now,” and they might go back to their room and not get something that they really wanted.

Other nurses believed, however, that the nursing staff should be the ones to initiate contact and access: “But it needs to be arranged where, I think, the [patients] can’t get as close, if that makes sense . . . we’re available, but we’re not, you know, right there.”

Some nurses believed that patients’ greater access to communicate with the staff invited more disruption in daily tasks. One nurse noted, “You have more access to the patient. They can come and talk to you. Whereas before you could sit at the work stations and they couldn’t come up and interrupt you and break your concentration.” For this particular nurse, the greater access was not perceived as positive. This same nurse commented that the glass barrier decreased the demanding behavior of some patients:

They couldn’t be as demanding as—they could be just as demanding, but they couldn’t get to you to be as demanding until you went to them and see what they wanted after whatever you were concentrating on doing was done.

Some nurses noted that the frequent interruptions broke their train of thought and made it difficult to complete tasks on time. One nurse felt that the interruptions were difficult to manage: “I seem to be getting off later, and I’m charting after hours, because I can’t get it all done, because I’m constantly being asked to stop to do something.”

These nurses believed that the glass enclosure served as a form of protection from interruptions and privacy violations and allowed the staff to freely communicate with one another without having to worry about the patients overhearing conversations. One nurse observed that the barrier served as a tool for better communication among the staff:

You feel more inclined to communicate better. I think you’re more forthright with the window up in communicating what really needs to be said nurse-to-nurse, or nurse-to-doctor . . . I think you’re more forthright and more honest in your communication style with the window up.

The glass enclosure provided an environment at the nursing station that fostered better communication between the staff members, and without it, not all staff felt comfortable sharing pertinent information given the possibility of patients being within earshot.

Patients’ Experiences

The patient participants, on the other hand, unanimously preferred the open nursing station. Patients described dramatically different experiences of a closed station and an open one. Major themes reflecting patient experiences of the glass barrier were feelings of imprisonment/freedom and emotional separation/togetherness.

Imprisonment and freedom. The glass barrier at the nursing station physically separated nurses from patients and subtly suggested that the separation was because the patients were being punished and needed to be physically barred from the station. For one patient, the glass barrier,

just felt like a huge separation. To me it felt like a little kind of a type of degrading type thing. Felt like we were being separated for different reasons . . . It almost felt like more of a prison-type thing. It was actually a little intimidating, a little scary.

Another patient noted, “That glass made me feel like I was in jail or something, institution . . . so, the glass to me [felt] like you’re incarcerated or something. I feel safer with the glass down.” To get attention at the nurses’ station, patients would need to bang on the window. One patient felt that when he banged on the glass, the action invited the wrong kind of attention: “With the glass, anybody working on the computers, they couldn’t hear unless you beat on the glass. Then they thought something was going on, like fighting or something.” Another patient shared a similar experience:

You don’t feel like you’re separated by any partition, glass, anything that hinders you from being able to communicate what your needs are, without having to actually go knock on a window, stand there as if you’re some kind of bank robber . . . it’s like you’re on the outside and that you are some kind of criminal or something. You’ve done something that’s really so bad that they feel they need to be that separated from, the rest of the group.

Patient participants felt that the glass separated them from the staff as a form of judgment or punishment for their mental illness. The glass was perceived as a physical barrier to protect staff from patients. Some patients felt that the off-limits nature of the nursing station barrier encouraged feelings of seclusion and isolation.

The glass barrier also invited feelings of confinement—feelings that may complicate and interfere with treatment and recovery. One patient said,

You have people that are going through problems, mental problems, they tend to want to be free. They don’t want to come to a place and be locked up and confined and think about this [as a] jail, you know?

Instead of feeling like a place of comfort and care, the glass barrier felt like a prison for some patients: “You don’t want to talk to nobody through glass. That reminds you of being incarcerated. That’s what they do in prison. You talk behind glasses in jails, behind glasses. Nobody wants to feel like they’re incarcerated like that.” With the glass enclosure, patients felt that they had a small role and little power in how they communicated with the nursing staff.

With the glass enclosure, patients were not able to freely communicate with the staff at the nursing station. The removal of the glass barrier gave the patients a sense of freedom: “You can breathe freely. It’s like I say, [you’re] not stuck in a box.” It gave patients more control and freedom in how they accessed the nursing staff. One patient shared this experience of the removal of the glass:

The first thing I noticed when I came through the door was that openness just coming through the door. I wasn't 100 percent, but that was the first thing that caught my attention was that it was all gone. It is just open. It's free.

Separation and togetherness. The patients felt closer to the staff and found them more easily accessible and attentive to their needs. One patient found comfort in the ability to visually see and find staff: "They're always in sight. You're not trying to figure out where they are. Because it's so open that even me being on the other end of the hall, I can tell if someone is down there or not." Another patient also felt safer knowing that the staff would be able to quickly respond to emergencies: "I feel they can get to me quicker, or if something happens, they can look out more clearly than looking out through glass and see what's going on and come to your aid quicker." The patients felt comforted knowing that the staff could respond to their needs quickly.

The removal of the glass brought patients and staff together, sharing the same space. One patient said,

I feel safe knowing that I can see them. They can see me, and I can talk to them just like anyone else would without some—glass, and walls, and things that are going to separate us instead of bring us together.

One patient felt that the staff interacted more with patients than before:

They interact with them [patients] and act like they're a part of it. And I think that's a lot better for the patients. Because they don't feel so down and out and alone by their self . . . the staff helps build confidence and your self-esteem.

One patient called the unit a "safe haven"; it was a place that was free of judgment. The patient observed,

I don't feel judged in here. We already know that when we walk out the door that there will be a judgment that comes upon whoever knows we're here. Inside, regardless, it's a safe haven for a period of time until we can regroup and start recovery. But until then while you're in here, it's very important for us to feel accepted, okay, safe, wanted here.

Discussion and Implications

The findings from this study contribute to the literature on inpatient psychiatric unit design and the role of the environment on psychiatric inpatients and the staff members who care for them. Our findings show that structural changes in acute psychiatric environments can affect the psychosocial and interpersonal environments in existential and dramatic ways. Our findings showed that patients unanimously agreed that their experience of the unit since the renovation had been freeing and comforting. Some nurses liked the increased interaction with patients, but others interpreted these interactions as unnecessary interruptions from their work. When the nursing station was enclosed, patients felt judged and imprisoned whereas some nurses felt safe

and secure in their communication. Other nurses, however, felt cut off from their patients and saw the glass enclosure as the symbol of that separation.

The findings from our study can be situated not only in the body of knowledge about psychiatric hospital design in general, and nursing station design in particular, but also in the literature about the role of the inpatient environment on the health and well-being of psychiatric inpatients. Although no studies could be found that studied only the physical design of nursing stations in inpatient psychiatric environments, other studies support a general psychoenvironmental approach to hospital design as a means to positively affect patient and staff outcomes (Gross, Sasson, Zarhy, & Zohar, 1998). Others concur suggesting that psychiatric redesign can improve patient safety, improve patient care, and, more specifically, increase the number of interactions between patients and nurses (Delaney & Johnson, 2014; Johnson & Delaney, 2006; Ulrich & Zimring, 2004; Whitehead, Polsky, Crookshank, & Fik, 1984).

Maintaining confidentiality was a concern among the majority of nurse participants. Some anecdotal evidence showed that some patients had overheard private conversations at the open nursing station. Brennan, Chugh, and Kline (2002) found that office employees complained of an increase in disturbances and a lack of privacy in an open office design. These findings parallel some of the nurses' experiences of increased interruptions and privacy violations with the open nursing station. Brennan et al. (2002) recommended balancing an open environment with smaller, more private rooms for discussions and meetings, which is consistent with the latest design guide from the National Association of Psychiatric Health Systems (Hunt & Sine, 2014), which recommends an open nursing station and smaller areas for patient-focused conversations.

This study raises the question of how to bring together patients and nurses in a freeing yet therapeutic environment where both patients and nurses have open avenues of communication yet feel comfortable in their environment. This balance involves nurses maintaining boundaries and rules yet participating fully in treatment and therapeutic communication. The National Association of Psychiatric Health Systems Design Guide (Hunt & Sine, 2014) recommends that hospital administrators plan for social and therapeutic interactions around the nursing station by providing comfortable sitting areas near the open nursing station. Units like these are intentionally designed to facilitate better nurse-patient relationships.

Stenhouse (2011) found differences between patients' perceived expectations of staff and their perceived experiences of receiving help during inpatient psychiatric stays (patients thought that they would receive more help than what they reported receiving). Nursing staff did not generally approach patients to interact, and when patients sought help, nurses were often too busy. This disconnect between patients' expectations of nurses and their actual experience is reflected in our study: The removal of the glass barrier removed the nurses' expectation that the station was their own and that they determined the time and place of patient interaction. With the open nursing station, patients were given equal latitude in initiating interaction. Shattell et al. (2008) found that both patients and nurses wanted "a milieu of mutual respect with ample time to forge relationships" (p. 248). However, this contrasts with our finding that some nurses were not entirely receptive to the idea of sharing the nurses' station and once again demonstrates a disparity between expectation and actual experience.

An open nursing station may improve the ability of nurses to help patients by improving their availability and accessibility, which could improve patient experience and patient satisfaction. This could counter troubling results from previous studies that have shown that psychiatric patients felt that they were infrequently helped by nursing staff despite the expectation that the nursing staff's purpose on the unit was to help them (Alexander, 2006; Henderson et al., 2007; Shattell et al., 2008; Stenhouse, 2011). It is our hope that attention to an open nursing station design, such as that outlined in our study, could improve patient satisfaction with inpatient psychiatric nursing care and serve to support recovery-based models of care. In addition, our work supports the broader notion that nurses' presence and close proximity to their patients promote self-control among persons who might be prone to violence (Salzmann-Erikson, Lützn, Ivarsson, & Eriksson, 2008). Closely shared space that enabled interactions between nurses and patients may be a strategy to decrease violence by patients (Kontio et al., 2014). This closer sharing of space, which in our study resulted from removal of a partition between staff areas and patient areas, could be considered even in units without nursing station enclosures, as a strategy that may lead to decreased feelings of loneliness among patients and greater feelings of safety, and that could have implications for patients for years to come. However, this must be balanced with the issue of too tight spaces that might lead to crowding and noisy conditions (Johnson & Delaney, 2006) and to an increase in stress among those sharing it.

Our study does have limitations. For one, the patient sample was primarily Black/African American, and the nurse sample was primarily Caucasian. Also, the study was conducted in the southeastern United States and there was a lag in time between the change in the nursing station and this study, which could have influenced the findings. Potential patient participants who were patients on the unit before the unit was redesigned said that they could not remember what it was like when the nursing station was enclosed. Perhaps we would have had a wider variety or a larger patient sample had we interviewed patient participants closer to the actual time of the renovations. Further studies should include a more diverse sample (race/ethnicities, geographies, etc.) and should consider how or if culture plays a role in the perception of space and distance on inpatient acute care units. Notwithstanding these limitations, special attention should be paid to bringing patients and nurses together in a freeing yet therapeutic healing environment that allows ease of access to care, yet respects the boundaries of the nurse and patient relationship and the need for confidentiality.

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Author Roles

Mona Shattell: research design, data analysis, overall management of the project, wrote the article; Robin Bartlett: research design, data analysis, wrote the article; Kyle Beres: data analysis, wrote the article; Kelly Southard: data collection, wrote the article; Claire Bell: data collection, wrote the article; Chris Judge: data collection, wrote the article; and Patricia Duke: data collection, wrote the article.

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