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Exploring the Barriers and Facilitators to Ensuring the Safety of Hospitalized Patients in Psychiatric Wards from Nurses' Perspectives: A Qualitative Study

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Abstract

Background: *Patient safety in psychiatric wards involves unique challenges beyond typical healthcare concerns, requiring specialized protocols to address risks such as self-harm, aggression, and environmental hazards. Nurses, as frontline caregivers, play a critical role in ensuring safety while balancing patient autonomy and recovery. This study explores nurses' perspectives on barriers and facilitators of patient safety in psychiatric settings. This study, conducted in Qazvin City, Iran., addresses a gap in context-specific qualitative research.*

Methods: *A descriptive qualitative design was employed, following the COREQ checklist, with semi-structured interviews conducted at three psychiatric wards in 22 Bahman Teaching Hospital, Qazvin City, Iran. A total of 19 registered nurses with at least one year of psychiatric experience were recruited, ensuring diversity in experience, gender, and ward type. Data were collected via an interview guide covering safety perceptions, barriers, facilitators, and improvement strategies. Thematic analysis, using both inductive and deductive approaches, was employed to extract key themes from the data, supported by NVivo 12. Rigour was enhanced through member checking, triangulation, and reflexive journaling.*

Results: *Four themes were extracted through iterative coding and categorization of interview data, revealing: (1) Perceptions of patient safety, emphasizing physical, emotional, and cultural dimensions; (2) barriers, including staffing shortages, inadequate training, patient-related challenges (e.g., aggression, substance use), and environmental constraints (e.g., poor ward design); (3) facilitators, such as effective communication, teamwork, supportive management, and comprehensive training; and (4) strategies, including improving staffing, enhancing training, modifying environments, and implementing evidence-based protocols. Nurses highlighted emotional safety and cultural competence as critical to reducing incidents and fostering trust. These themes provided a deeper understanding of how systemic, environmental, and relational factors interact to shape patient safety, highlighting the need for tailored interventions in psychiatric care.*

Conclusion: *Patient safety in psychiatric wards involves a complex interplay of systemic, environmental, and relational factors. Addressing barriers such as understaffing and training gaps while leveraging facilitators such as communication and teamwork can enhance safety outcomes. Context-specific strategies, including tailored protocols and ward redesign, are essential for creating safe, therapeutic environments. These findings offer actionable insights for policymakers and clinicians to improve psychiatric care safety.*

Keywords: Patient safety, Psychiatric nursing, Mental health, Thematic analysis, Qualitative research.

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Introduction

Patient safety is a cornerstone of healthcare quality and a fundamental component of nursing practice across all clinical settings. The World Health Organization (WHO) defines patient safety as the prevention of errors and adverse effects associated with healthcare, emphasizing the importance of safeguarding patients from harm during care delivery[1]. In psychiatric wards, patient safety extends beyond typical concerns like medication errors or falls, encompassing unique risks such as self-harm, aggression, absconding, and coercive interventions like restraints or seclusion. These challenges demand specialized knowledge and protocols tailored to mental health disorders and the therapeutic environment[2].

Psychiatric inpatient settings present distinct safety risks due to patients' behavioral manifestations and environmental factors. Patients may face heightened risks of suicide, violence toward others, or harm from ward design flaws, such as inadequate observation areas or insufficient security measures[3, 4]. Nurses, as frontline caregivers, are pivotal in monitoring mental and physical health, identifying early signs of behavioral escalation, and fostering a recovery-oriented environment. Balancing safety with patient autonomy and dignity is complex, as excessive control can undermine trust, while inadequate measures may increase harm[5]. Thus, ensuring patient safety in psychiatric wards requires careful integration of clinical and ethical considerations.

Nurses' continuous presence and direct patient interactions make their perspectives on safety barriers and facilitators

critical for developing effective interventions. Organizational barriers, such as staffing shortages and inadequate training, alongside environmental issues like poor ward layouts, can heighten risks and compromise care quality[6]. Conversely, effective communication, teamwork, and supportive leadership can enhance safety and improve outcomes[7]. However, despite the recognized importance of their role, there remains a paucity of qualitative research that captures nurses' lived experiences and insights regarding safety challenges in psychiatric wards, particularly in situations where resource constraints may further complicate safety efforts. While existing researches have documented common safety risks like self-harm and aggression in inpatient mental health settings, these studies often rely on quantitative data or broad overviews, overlooking the nuanced, lived experiences of nurses in managing these issues daily[3, 4]. This leaves a notable gap in qualitative explorations that delve into nurses' firsthand insights, particularly in psychiatric wards where cultural and resource constraints may amplify challenges, which this study seeks to fill by providing context-specific evidence from an Iranian setting.

The barriers to ensuring safety in psychiatric wards are multifaceted, often reflecting the interplay between organizational, environmental, and individual-level factors. Drawing on the Job Demands-Resources (JD-R) model[8], which suggests that high job demands, such as organizational barriers, can cause burnout and safety issues, these demands must be balanced by resources, such as supportive leadership. These factors interact dynamically in psychiatric wards. Organizational barriers may include inadequate staffing, insufficient training in de-escalation techniques, limited access to specialized equipment, and a lack of institutional support for safety culture[9, 10]. These barriers, if unaddressed, may result in preventable adverse events, reduced quality of care, and negative psychological outcomes for both patients and staff. Conversely, key facilitators of patient safety in psychiatric wards include effective teamwork, supportive leadership, ongoing education, patient-centered care, and well-designed environments[11]. By viewing barriers as demands that put pressure on staff capacity and facilitators as resources that strengthen resilience, this approach shows how imbalances can increase risks. It emphasizes the need for focused strategies to bring back balance.

In Iran, psychiatric inpatient facilities face additional challenges, including resource scarcity, high patient loads, and limited specialized training, yet research on these issues remains limited, particularly from nurses' viewpoints[12-14]. Within Iran's healthcare system, where mental health services are gradually more incorporated into primary care but the system still suffers from underfunding and the unequal distribution of resources, the cultural factors, such as the stigma surrounding mental illness, often delay the seeking of help and make care delivery more complicated[15]. To illustrate, family participation is regarded as an essential element in Iranian culture, but due to the wards' lack of facilities, this may lead to more isolation and increased safety risks. The complications that are specific to the context, coupled with the limited availability of advanced psychiatric training programs, show the necessity of urgent local studies that will guide the development of culturally sensitive safety measures.

This study addresses a gap in context-specific qualitative research by exploring nurses' perspectives on barriers and facilitators to patient safety in psychiatric wards in Qazvin City, Iran. Through an in-depth qualitative lens, this research delves into nurses' lived experiences to uncover subtle dynamics and interconnections in safety practices, ultimately aiming to generate practical, evidence-informed recommendations that can guide the development of tailored protocols and foster more resilient, therapeutic environments in psychiatric care. By capturing their lived experiences, the study aims to inform tailored safety protocols and interventions, contributing to safer and more therapeutic psychiatric care environments.

Materials and Methods

This study employed a descriptive qualitative research design to explore nurses' perspectives on the barriers and facilitators of ensuring the safety of hospitalized patients in psychiatric wards. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist[16] was followed to ensure methodological rigor, and a completed checklist was provided as supplementary material. The research was carried out over the period of July 2025 to September 2025, to take into account and to study the seasonal changes in dynamics of the wards as well as their possible effects on the perception of safety, one of which was holidays-induced staff fluctuation. The Ethics Committee of Qazvin University of Medical Sciences granted the study ethical approval (Approval No. IR.QUMS.REC.1404.096). The main interviewer was the first author (L.D.) who, had experience in nursing qualitative research but no past professional ties with the participants to minimize bias and encourage free conversation. Reflexivity was kept up by her journaling of assumptions and discussing them in team meetings to ensure the interpretations were still based on the participants' voices. Semi-structured, in-depth individual interviews were used as the primary data collection method, enabling the exploration of personal experiences, perceptions, and professional insights related to patient safety within psychiatric care contexts. This approach could allow participants to elaborate on sensitive safety-related issues that might not surface in group settings while still providing opportunities for thematic depth and richness[17]. The interviews were guided by an interview protocol that encouraged participants to reflect on both structural and personal factors affecting patient safety while allowing flexibility in exploring emergent topics. Thematic analysis was employed to analyze audio-recorded and transcribed data, integrating insights from interview transcripts and field notes. To enhance trustworthiness, methodological triangulation was achieved by integrating data from interview transcripts, field notes, and demographic questionnaires. Investigator triangulation involved two researchers independently coding the data, followed by joint sessions to compare and refine the codes, resolve discrepancies, and finalize the thematic framework. Disagreements between coders, such as differing interpretations of a quote's emotional vs. environmental emphasis, were addressed through facilitated discussions until consensus was reached, often by cross-referencing field notes for contextual clues. Conflicting information from sources (e.g., a transcript suggesting strong teamwork contradicted by field notes on observed tensions) was reconciled by prioritizing participant narratives while noting divergences in the reflexive

journal, which helped refine themes and bolster overall credibility. Rigour was further supported by member checking, where a summary of preliminary findings was shared with eight participants to verify accuracy, and by maintaining a reflexive journal to document researcher assumptions and decisions, minimizing potential bias. Data triangulation, which incorporates multiple sources, ensures consistency and provides a comprehensive understanding of the barriers and facilitators of patient safety in psychiatric wards.

This study was conducted at 22 Bahman Teaching Hospital in Qazvin, Iran, across three psychiatric wards selected for their distinct characteristics, representing diverse psychiatric care settings. The selected sites perfectly illustrate the main aspects of psychiatric care in Iran: the emergency ward denotes the high-acuity public services that are usually found in urban areas, the men's and women's wards are indicative of gender-segregated, long-term care that is typical in Iranian hospitals, and the teaching hospital situation is a reflection of the resource limitations and training variations that are prevalent throughout the country. Although this selection is not exhaustive of all Iranian contexts, it still provides transferable insights into some of the common challenges like underfunding and cultural influences that are already present in the mental health system of the whole country. The first site, an emergency ward for adults with severe mental illness, has 18 beds and offers psychiatric treatment for a variety of conditions and thus gives off insights into the challenges of safety in high-acuity psychiatric areas. The second site, the 30-bed Men's ward, treated both inpatients and outpatients and thus allowed the examination of safety policies in an environment that was both research- and teaching-oriented. The third site, a women's ward with 30 beds, deals with long-stay female patients with severe mental disorders and thus draws attention to the problem of continuous safety management and resource limitation. The wards were selected not only because of their distinct patient populations (acute vs. chronic, male vs. female), and care delivery models (emergency vs. long-term), but also due to operational difficulties, thus guaranteeing a wide representation of the different psychiatric care contexts in Iran.

Purposive sampling[18] was used to recruit registered nurses with direct patient care responsibilities in psychiatric wards, ensuring the inclusion of information-rich cases capable of providing in-depth insights into safety-related practices. The inclusion criteria were (a) current employment in a psychiatric ward or hospital, (b) at least one year of experience in psychiatric nursing, (c) direct involvement in patient safety management (either formal or informal), and (d) willingness to participate in a recorded interview. Exclusion criteria included nurses with less than one year of psychiatric experience or those in non-clinical roles (e.g., administrative positions). Participants could withdraw at any time without consequences, as outlined in the consent process, with no withdrawals recorded during the study. Data saturation, defined as the point at which no new themes emerged from additional interviews, guided the final sample size[19]. On the basis of similar qualitative studies, we anticipated 20–25 interviews; saturation was reached after 19 interviews, and two additional interviews were conducted to confirm the redundancy of the results. This initial estimate was informed by previous Iranian psychiatric nursing study[14] and the need to achieve maximum variation across five key dimensions (experience, gender, education, ward type, shifts). The process for reaching saturation involved iterative analysis: after every 3-4 interviews, transcripts were preliminarily coded, and if novel insights emerged, recruitment continued with a focus on gaps (e.g., seeking more senior nurses); true saturation was confirmed when team consensus identified thematic redundancy, ensuring the sample was robust yet efficient. Operationally, saturation was determined when no new codes or subthemes appeared in three consecutive interviews, as assessed through concurrent data analysis. The decision was made collectively by the research team (L.D., N.J.P., and F.S.S.) during bi-weekly review meetings, where preliminary coding from recent transcripts was compared against the evolving thematic framework. This ongoing analysis informed recruitment by signaling when to slow down and focus on underrepresented subgroups, such as male nurses or those from rehabilitation wards. The total of 21 interviews (19 to saturation plus 2 confirmatory) was deemed adequate for maximum-variation sampling, as it encompassed a broad spectrum of experience levels (2-25 years), genders (79% female, 21% male), educational backgrounds, and ward types, ensuring rich, multifaceted insights without redundancy, consistent with guidelines for thematic saturation in diverse samples. Maximum variation sampling ensured diversity across years of experience (early-career, mid-career, senior), workplace settings (acute psychiatric hospital, rehabilitation, general hospital psychiatric ward), educational levels (diploma, bachelor's, master's), gender, and shift patterns. Recruitment was facilitated through collaboration with nursing supervisors, who distributed study information sheets and invited interested nurses to contact the research team directly to avoid coercion. The anonymity of the respondents and participants was maintained so that their contribution would not affect the ratings of their performance or the relationships within the organization. The consent to participate in the study was obtained voluntarily and individually, by private meetings where the consent along with its advantages and disadvantages, the right to withdraw at any time without being subjected to any negative treatment, and other related matters were discussed as written and orally; only after signing did the participants give their informed consent and continue on. Participant demographics are summarized in Table 1 (presented in the Results section) to evaluate sample diversity and transferability, emphasizing differences in age, gender, experience, education, and ward types.

The primary research instrument was a semi-structured interview guide designed to elicit detailed[20] accounts of barriers and facilitators of patient safety in psychiatric wards. The guide was developed following an extensive review of the literature on patient safety in mental health care and discussions with experts in psychiatric nursing and hospital safety management. The interview topics covered five core domains: (1) nurses' perceptions of patient safety in psychiatric settings, (2) perceived barriers to maintaining safety, (3) facilitators or enablers that improve safety, (4) organizational and systemic influences on safety, and (5) recommendations for improving safety practices. Example questions included *"Can you describe a situation where you felt patient safety was at risk in your ward?"* and *"What strategies or conditions help you feel confident that your patients are safe?"* Probing

questions encouraged participants to elaborate on context, contributing factors, and outcomes.

The guide underwent expert review by three psychiatric nursing faculty members and two hospital safety officers, who assessed clarity, relevance, and comprehensiveness. Cognitive interviews with two psychiatric nurses were conducted to refine the wording and sequence of the questions. These pilot interviews resulted in minor adjustments, like making some probes more open-ended to encourage deeper responses, but no major structural changes were needed. A demographic questionnaire collected participants' age, gender, years of nursing experience, years in psychiatric care, educational qualifications, and average number of shifts per month. Field notes were recorded during and immediately after each interview to capture non-verbal cues, emotional tone, and contextual observations. All instruments were initially developed in Persian and underwent forward–backwards translation to ensure conceptual accuracy and linguistic clarity for potential dissemination in English[21].

The forward translation was carried out by two bilingual members of the research team (L.D. and N.J.P.), who are accustomed to the psychiatric nursing terminology. The backward translation to Persian was carried out by a different bilingual translator with medical research expertise who had not been part of the study beforehand. To ensure the conceptual equivalence, the team placed the original and back-translated versions side by side and discussed the differences, ensuring that the questions kept their original meaning in both languages, particularly around culturally sensitive concepts like patient autonomy and stigma. This process confirmed strong alignment, with only slight phrasing tweaks for natural flow in English.

Following ethical approval, participant recruitment was carried out as described in the "Sample" section. Individual, face-to-face interviews were conducted in private meeting rooms at the participating hospitals to ensure confidentiality and minimize workplace interruptions. The interviews lasted between 45 and 75 minutes, depending on the participants' responses. The interviewer, an experienced qualitative researcher with a background in psychiatric nursing, began each session with a rapport-building conversation, followed by an explanation of the study purpose and a review of the consent form. The semi-structured guide was used to ensure comprehensive coverage of topics while allowing flexibility in pursuing emerging lines of discussion. An observer was not present during the interviews to encourage openness. The interviews were audio-recorded with the participants' permission, and field notes were taken immediately after each session. Data collection continued until saturation was reached, as confirmed by the research team's ongoing thematic review of transcripts.

Thematic analysis was conducted following the six-step approach of Braun and Clarke (2006)[22], with two researchers independently coding transcripts to capture diverse nurses' perspectives. Initial codes were generated inductively to reflect participants' unique experiences, followed by deductive coding to align with existing safety literature. Discrepancies in coding or theme interpretation were resolved through collaborative discussions, ensuring balanced representation of viewpoints and minimizing bias. Peer debriefing with qualitative research colleagues unaffiliated with the study helped challenge assumptions and further reduce bias. An audit trail documented all research decisions, coding revisions, and analytic memos. NVivo 12 software was used for data organization and retrieval. While the emphasis remained qualitative, counts and percentages were used descriptively to indicate the relative frequency with which certain barriers or facilitators were mentioned across participants, enhancing transparency in presenting the prominence of key themes. To start the coding workflow, the open coding method was applied to pinpoint the first patterns present in the data. It then moved on to axial coding to study the connections between the different codes (for instance, linking staffing shortages to increased aggression risks) and finally ended with selective coding that helped to narrow down the core themes. The discrepancies between the coders were solved in bi-weekly meetings to reach a consensus; in very few instances when there was still disagreement, a third coder (M.B.) was brought in to arbitrate and make sure the interpretation was fair and balanced. A good example is the ambiguous quote "I had a patient screaming... and all I had was my general training" which could be categorized under the subtheme 'Inadequate Training' contained in the larger theme 'Barriers to Ensuring Patient Safety' thereby demonstrating the insufficient skills in handling crises at that moment. The number of occurrences and percentages were shown descriptively to indicate the relative importance of themes amongst the participants thus increasing the transparency of the process without suggesting statistical generalizability, which is a proper approach in qualitative research for the purpose of emphasizing. The completed COREQ checklist together with the additional materials such as the interview guide and reflexive journal excerpts can be found in the journal's online supplementary repository.

Results

A total of 19 registered nurses participated in the study. The mean age of the participants was 38.5 years (SD±7.8), with an average of 11.2 years (SD±6.5) of experience in psychiatric nursing. The majority of the participants were female (78.9%) and held a bachelor's degree (63.2%). The participants worked in various psychiatric settings, including acute psychiatric hospitals (42.1%), psychiatric rehabilitation hospitals (26.3%), and psychiatric wards in general hospitals (31.6%). Table 1 provides an overview of the participants' demographic and professional characteristics.

Table 1. Demographic and professional characteristics of the participants

Characteristic	N (%) or Mean±SD
Age (years)	38.5±7.8
Gender	
Female	15 (78.9%)

Male	4 (21.1%)
Years of experience in psychiatric nursing	11.2±6.5
Education level	
Diploma	4 (21.1%)
Bachelor's degree	12 (63.2%)
Master's degree	3 (15.8%)
Workplace setting	
Emergency psychiatric ward	8 (42.1%)
Men's psychiatric ward	5 (26.3%)
Women's psychiatric ward	6 (31.6%)

Key Themes Identified: Thematic analysis of the interview data revealed four overarching themes and corresponding subthemes related to the barriers and facilitators of ensuring patient safety in psychiatric wards. Through iterative coding, these themes were derived beginning with open codes (i.e., "staff shortage delays" from quotations on response times) which gradually changed into axial codes linking concepts (e.g., staffing - risk escalation) and finally to selective codes through prevalence and interconnections; core themes were refined. Deviant cases like nurses perceiving temp staff as sometimes innovative despite risks were acknowledged and reconciled via team agreement to guarantee equitable representation. These themes are summarized in Table 2, which includes descriptions of each theme and subtheme to clarify their scope and relevance.

Table 2. Themes, subthemes, and descriptions generated in this study

Themes	Subthemes	Description
(1) Perceptions of Patient Safety in Psychiatric Wards	1a. Definitions of patient safety	Nurses' views on safety as a dynamic interplay of physical, emotional, and cultural factors, emphasizing a secure and trusting environment.
	1b. Importance of patient safety	The critical role of safety in supporting patient recovery, staff well-being, and institutional trust.
	1c. Unique challenges in psychiatric settings	Specific risks in psychiatric care, such as managing crises, balancing autonomy with safety, and addressing stigma.
(2) Barriers to Ensuring Patient Safety	2a. Staffing issues	Challenges from low nurse-to-patient ratios, reliance on temporary staff, and resulting delays in care.
	2b. Inadequate training	Gaps in skills for de-escalation, trauma-informed care, and managing complex patient conditions.
	2c. Patient-related factors	Issues like aggression, non-compliance, substance use, and comorbidities complicating safety efforts.
	2d. Environmental constraints	Ward design flaws, such as cramped spaces, poor acoustics, and outdated infrastructure, increasing risks.
(3) Facilitators of Patient Safety	3a. Effective communication	Information exchange at relational levels (staff-staff, staff-patient, staff-family) reducing incidents and building trust, distinct as a foundational process enabling other facilitators.
	3b. Teamwork and collaboration	Collective actions and interdisciplinary synergy enabling rapid responses and shared accountability, differentiated by its focus on operational coordination beyond mere communication.
	3c. Supportive management	Leadership providing resources, visibility, and a blame-free culture to enhance safety, separated as it operates at a systemic level to empower communication and teamwork.
	3d. Comprehensive training programs	Practical, scenario-based training building confidence and competence in diverse scenarios.
(4) Strategies for Enhancing Patient Safety	4a. Improving staffing levels	Recommendations for higher ratios, permanent staff, and support roles to match patient needs.
	4b. Enhancing training and education	Calls for regular, immersive training, including simulations and cross-disciplinary skills.
	4c. Modifying the physical environment	Proposals for better ward layouts, safety features, and therapeutic design elements.
	4d. Implementing evidence-based safety protocols	Advocacy for adaptable, research-based guidelines tailored to local contexts.

1: Perceptions of Patient Safety in Psychiatric Wards (1a: Definitions of Patient Safety): Nurses articulated a broad and nuanced definition of patient safety in psychiatric wards, viewing it as a dynamic interplay of physical, emotional, and relational factors unique to mental health care. They emphasized that safety goes beyond preventing accidents,

encompassing the creation of a secure and trusting environment where patients can heal. Several participants highlighted emotional safety as paramount, arguing that patients' mental states heavily influence their physical well-being. One nurse shared:

"Safety isn't just locking up sharp objects—it's about patients feeling like they're in a place where they won't be judged or abandoned. If they're emotionally safe, they're less likely to lash out or hurt themselves." (Participant 12, Female)

Another nurse focused on the practical aspects of safety:

"For me, it's about the basics—making sure they're not overdosing on meds, not sneaking contraband, and not getting into fights. However, it's also about watching for those quiet ones who might be planning something worse." (Participant 6, Male)

Additionally, nurses pointed to the role of cultural sensitivity in their definitions, noting that safety includes respecting patients' backgrounds and beliefs. A nurse explained: "Some patients come from cultures where mental health is taboo. Safety for them means we're not pushing treatments they don't trust—it's about building that bridge first." (Participant 15, Female)

These perspectives reveal a holistic view of safety that integrates physical security, emotional stability, and cultural competence and is tailored to the complexities of psychiatric care. This comprehensive definition echoes the discourse around psychological safety and mental health in literature; in this scenario, the emotional and cultural aspects lower the danger risks, thus, the JD-R model gets an extension, and is then able to demonstrate that the demands are met with relational resources.

1b: Importance of Patient Safety: The nurses underscored patient safety as the foundation of effective psychiatric care, linking it to patient recovery, staff well-being, and institutional reputation. They argued that a safe environment is a prerequisite for any therapeutic progress, as fear or instability undermines treatment efficacy. One nurse elaborated:

"You can have the best therapy plans, but if a patient's scared or the ward's chaotic, none of it sticks. Safety's what lets them open up and start healing." (Participant 5, Male)

The participants also connected safety to staff safety and morale, noting that incidents such as assaults or self-harm events erode confidence and increase burnout. A nurse reflected: "I've seen colleagues quit after a bad incident because they didn't feel safe. When we're secure, we can focus on care instead of just surviving the shift." (Participant 17, Female)

Moreover, nurses highlighted broader implications, such as legal and ethical responsibilities. One said:

"If we fail on safety, it's not just the patient who suffers—it's lawsuits, guilt, and families who lose trust in us. It's the whole system that takes a hit." (Participant 18, Male)

This subtheme illustrates the cascading impact of safety, positioning it as a critical linchpin in psychiatric nursing. These connections reflect prior studies on safety climates, where enhanced safety correlates with lower burnout per the JD-R framework, emphasizing systemic ripple effects.

1c: Unique challenges in psychiatric settings: Nurses identified a host of distinctive challenges in psychiatric wards, including managing acute mental health crises, balancing patient rights with risk mitigation, and addressing the stigma that affects care delivery. They described how patients' fluctuating mental states—ranging from mania to deep depression—require constant adaptation. One nurse noted:

"One day, a patient's laughing and cooperative; the next, they're smashing a chair because their meds haven't kicked in yet. You've got to be ready for anything, all the time." (Participant 8, Female)

The ethical tension between autonomy and safety was a recurring concern. A nurse explained: "We had a patient who wanted to keep a belt because it was a gift from her dad, but it was a ligature risk. Saying no, one felt like taking away her dignity, but letting her keep it wasn't safe. Those calls are brutal." (Participant 11, Male)

The participants also cited external pressures, such as societal stigma, which can lead to underfunding or dismissive attitudes from other healthcare professionals. One nurse shared: "Sometimes, the ER sends us patients with a 'just deal with it' vibe, like mental health isn't as serious as a broken leg. It makes our job harder when we're already stretched thin." (Participant 16, Female)

These challenges highlight the specialized nature of psychiatric nursing, which demands resilience, ethical judgment, and advocacy skills beyond standard medical training. This subtheme echoes literature on ethical dilemmas in psychiatric care, where autonomy-safety tensions amplify demands under the JD-R model, particularly in stigmatized contexts.

2: Barriers to Ensuring Patient Safety: (2a: Staffing Issues): Staffing shortages were a dominant barrier, with nurses reporting that low ratios jeopardize safety daily. They described scenarios where understaffing led to delayed responses, missed observations, and heightened stress. One nurse noted:

"During a weekend shift, we had one nurse for 15 patients because someone called in sick. A patient climbed onto a table, threatening to jump, and I was alone, trying to talk him down while watching the others. It was a nightmare." (Participant 3, Female)

Nurses also criticized the overreliance on temporary staff, who often lack the rapport or knowledge needed for nuanced care. A participant said:

"Agency staff don't know that Mr. Jones gets paranoid at night or that Mrs. Smith hides pills. That gap in continuity is where mistakes happen." (Participant 10, Female)

Additionally, they noted the psychological toll, with understanding fostering a sense of helplessness. One nurse admitted:

"You leave a shift feeling like you failed because you couldn't check on everyone enough. It's exhausting, and it makes you dread coming back." (Participant 7, Male)

The presentation of the subtheme highlights the very negative aspects of staffing shortages in terms of safety for the patients and the staff. In line with JD-R theory, there is a clear connection through the shortages from high demands to burnout and safety issues, which is also the conclusion of quantitative studies on nurse ratios.

2b: Inadequate Training:Inadequate training was a significant hurdle, with nurses feeling underprepared for psychiatric-specific demands. They cited gaps in skills such as de-escalation, trauma-informed care, and managing dual diagnoses (e.g., mental illness and addiction). One nurse described:

"I had a patient screaming and throwing things, and all I had was my general nursing training. I didn't know how to calm him without making it worse—it was trial and error, and that's dangerous." (Participant 2, Male)

The participants also lamented the lack of refresher courses, especially as mental health trends evolve. A nurse said: "Ten years ago, we didn't see as much synthetic drug use. Now it's common, and I'm guessing how to handle someone tweaking out because my training's outdated." (Participant 13, Female)

Newer staff felt particularly vulnerable, with one noting the following: I came from a med-surg, and my first week here, I was lost. No one taught me how to spot a suicide risk beyond the obvious—it's like they expect you to just figure it out." (Participant 9, Female)

The gaps highlighted in this subtheme call for a continuous and specific education which is to be prioritized as a matter of urgency. This concurs with the literature on the lack of specialized training, where the unavailability of adequate resources per JD-R leads to an increase in risks in the developing psychiatric environments.

2c: Patient-Related Factors: Patient-related factors pose complex barriers, with nurses citing behaviors such as aggression, non-compliance, and self-harm as persistent challenges. These issues often stem from patients' conditions, making them difficult to predict or control. One nurse recalled: "We had a guy who'd punch walls when his voices got loud. You can't reason with him in that state, and it sets off the whole ward—everyone gets edgy." (Participant 19, Female)

Substance use was another complicating factor. A nurse explained: "Patients smuggle in stuff like meth or booze, and suddenly you're dealing with someone who's not just depressed but wired and aggressive. It's a safety minefield." (Participant 4, Male)

Nurses also mentioned the challenge of co-morbidities, such as physical health issues intertwined with mental illness. One said: "A diabetic patient stopped eating because she thought her food was poisoned. Keeping her safe meant managing her sugar levels and her delusions—double the work." (Participant 14, Female)

These examples highlight how patient-driven variables test the limits of safety protocols. These factors illustrate unpredictable demands in JD-R terms, consistent with studies on behavioral risks in mental health settings.

2d: Environmental Constraints: Environmental constraints were a critical barrier, with nurses pointing toward design flaws such as cramped spaces, poor acoustics, and limited secure areas. They described how these issues amplify risks and hinder monitoring. One nurse explained:

"Our ward's got these narrow hallways where patients can corner you, and the noise bounces everywhere. A scream from one end can trigger panic across the unit." (Participant 1, Male)

The participants also flagged insufficient resources, such as outdated furniture or broken locks. A nurse said:

"Half our chairs are wobbly, and we've got a door that doesn't latch right. A patient could use that chair as a weapon or slip out unnoticed—it's a disaster waiting to happen." (Participant 12, Female)

Additionally, nurses noted how aesthetics affect safety, with bleak environments worsening patients' moods. One observed:

"The walls are peeling, and there's no natural light. It makes patients feel trapped, and that tension builds up until someone snaps." (Participant 5, Male)

In this subtheme, the physical environment is shown to either endorse or undermine the efforts directed at safety. It relates to the environmental psychology area of research, which states that design mistakes raise needs and cut off resources in mental healthcare.

3: Facilitators of Patient Safety: (3a: Effective Communication): These subthemes, while interrelated, were kept distinct based on coding: communication as process-oriented exchange, teamwork as action-based collaboration, management as systemic enablers, and training as skill-building inputs, with deviant cases (e.g., strong communication offsetting weak teamwork) justifying separation.

Effective communication was a vital facilitator, with nurses linking it to fewer incidents and better trust. They emphasized clear staff-to-staff exchanges, patient education, and family involvement as key components. One nurse highlighted shift transition:

"A solid handover is gold. Once, I got a heads-up about a patient stockpiling objects, and we caught it before he hurt himself. Without that, I would have been clueless." (Participant 7, Female)

Communication with patients was equally critical. A nurse shared: "I tell them why we're taking their shoelaces or checking their bags. When they get it, they're less likely to fight us on it—it's about respect." (Participant 11, Female)

Nurses also valued family input, with one noting the following:

"A mom told us her son calms down with music. We tried it, and it worked. Families know things we don't, and that helps keep things safe." (Participant 16, Female)

This subtheme highlights communication as a multifaceted safety enhancer. This facilitator supports literature on relational care, providing resources that mitigate demands per JD-R.

3b: Teamwork and Collaboration: Teamwork and collaboration were celebrated by nurses as the backbone of safety, enabling rapid responses and shared accountability. They described how cohesive teams anticipate risks and support each other under pressure. One nurse noted:

"A patient started choking on contraband, and within seconds, one nurse was doing Heimlich, another was calling the doc, and I was clearing the area. That's teamwork saving a life." (Participant 2, Female)

Interdisciplinary synergy was also key. A nurse said: "The occupational therapist suggested a routine that settled a restless patient. We wouldn't have thought of that—it's why we need everyone's input." (Participant 8, Female)

Nurses also noted the emotional lift that teamwork provides:

"When you've got a solid crew, you do not feel alone in the chaos. It's like a safety net for us and the patients." (Participant 3, Male)

This subtheme highlights the strength of collective effort in maintaining a secure ward. Aligning with interprofessional models, this enhances resilience against barriers like staffing shortages.

3c: Supportive Management: Supportive management was a facilitator for nurses, who praised leaders who prioritized safety through resources, advocacy, and responsiveness. Examples included funding new equipment or addressing staff concerns swiftly. One nurse shared:

"Our manager got us weighted blankets after we said patients were restless at night. It's small, but it's made an enormous difference in calming things down." (Participant 6, Male)

Another valued visibility: "My supervisor does rounds with us, not just sits in an office. She saw how crazy nights were and pushed for an extra hire. That's real support." (Participant 11, Female)

Nurses also appreciated a blame-free culture, with one saying: "When something goes wrong, our boss asks how to fix it, not who to punish. That makes us report issues instead of hiding them, and safety improves." (Participant 14, Female)

This subtheme positions management as a catalyst for a safety-first ethos. This reflects transformational leadership theory, where support buffers high demands in psychiatric environments.

3d: Comprehensive Training Programs: Comprehensive training was a game-changer, with nurses valuing programs that built confidence and competence across diverse scenarios. They praised practical, hands-on sessions and regular updates. One nurse noted:

"We had a mock code where a patient faked the meltdown—it was intense, but now I know exactly how to handle it without panicking." (Participant 4, Female)

Another highlighted specialized content: "A trauma workshop taught us how past abuse affects behavior. I used that to connect with a patient who'd been standoffish, and it de-escalated a tense moment." (Participant 19, Female)

Nurses also called for broader scopes, with one suggesting the following: "Training should cover legal stuff too—like when we can restrain someone. It's murky, and knowing the rules keeps us and patients safe." (Participant 5, Male)

This subtheme underscores training as a proactive shield against safety lapses. Consistent with simulation-based learning evidence, this resource addresses training barriers per JD-R.

4: Strategies for Enhancing Patient Safety:(4a: Improving Staffing Levels): Improving staffing was a top priority, with nurses advocating for higher ratios, better retention, and strategic scheduling. They suggested hiring permanent staff over agency workers and adding support roles. One nurse proposed:

"We need a core team, not just temps, and maybe mental health techs to handle routine stuff so we can focus on crises." (Participant 15, Male)

Another tied staffing to patient acuity: "On days when we've got multiple high-risk cases, we should double—say, four nurses instead of two. It's about matching resources to need." (Participant 4, Male)

Nurses also pushed for wellness initiatives, with one saying: "Offer mental health days or counselling—keep us from burning out so we stay sharp for the patients." (Participant 6, Female)

This subtheme offers concrete steps to bolster staffing resilience. These strategies align with acuity-based models in literature, reducing demands via resource allocation.

4b: Enhancing Training and Education: Enhancing training was endorsed by nurses, who called for in-depth, regular programs addressing psychiatric nuances. They suggested simulations, peer mentoring, and emerging issues such as telepsychiatry skills. One nurse envisioned:

"Quarterly boot camps with actors playing patients—it's real-time practice for aggression, delusions, you name it." (Participant 13, Female)

Another focused on accessibility: "Online modules we can do on slow shifts would help, especially for stuff like new meds or rare disorders we don't see often." (Participant 6, Male)

Nurses also wanted cross-training, with one noting: "Teach us some basic OT or social work tricks—little things that make a big difference in calming patients down." (Participant 7, Female)

This subtheme champions education as a safety cornerstone. Building on evidence-based education, this counters inadequate training barriers.

4c: Modifying the Physical Environment: Modifying the environment was a key strategy, with nurses proposing upgrades such as better layouts, safety features, and therapeutic design elements. One nurse explained:

"Wider halls, no dead ends, and a sensory room with dim lights and soft music—that's a ward built for safety and calm." (Participant 2, Female)

Another suggested technique: "Motion sensors in high-risk areas could alert us if someone's pacing or up to something—less invasive than constant checks but still effective." (Participant 17, Female)

Nurses also emphasized maintenance, with one saying: "Fix the broken stuff—locks, windows, call buttons. It's basic, but it's where safety starts." (Participant 8, Male)

This subtheme envisions a space that inherently supports safety goals. This draws from therapeutic design research, mitigating environmental constraints.

4d: Implementing Evidence-Based Safety Protocols: The implementation of evidence-based protocols was a favored strategy, with nurses advocating for clear, adaptable guidelines grounded in research. They suggested protocols for de-escalation, medication errors, and post-incident reviews. One nurse stated:

"A flowchart for when a patient's spiralling—like, try this, then that—takes the guesswork out and keeps us consistent." (Participant 3, Male)

Another pushed for inclusivity: "Protocols should reflect our population—say, how to handle a non-English speaker in crisis. Evidence has to fit our reality." (Participant 10, Female)

Nurses also wanted feedback loops, with one noting the following: "After every restraint, we should debrief and update the rules if something is off. That's how you make them work long-term." (Participant 9, Female)

This subtheme reflects a commitment to precision and evolution in safety practices. These align with high-reliability organization principles, integrating facilitators for sustained improvement.

Discussion

The present qualitative study explored nurses' perspectives on the barriers, facilitators, and strategies for ensuring patient safety in psychiatric wards. Through in-depth thematic analysis, four overarching themes emerged: perceptions of patient safety in psychiatric wards, barriers to ensuring safety, facilitators of safety, and strategies for enhancing safety. These themes collectively illuminate the multidimensional nature of patient safety in psychiatric settings, providing nuanced insights into how systemic, environmental, and relational factors converge to shape safety outcomes. The discussion below elaborates on these themes, situating them within the broader literature, exploring their interconnections, and highlighting their implications for practice and policy in psychiatric care.

The participants articulated a broad definition of patient safety, encompassing physical, emotional, and cultural dimensions. This aligns with prior work suggesting that safety in mental health care extends beyond the prevention of physical harm to include emotional security, therapeutic trust, and respect for patients' values[23, 24]. This theme reveals that safety in psychiatric wards is not merely about preventing physical incidents but also about creating an environment where patients feel valued and understood, a perspective that challenges traditional biomedical safety models. Notably, the emphasis on emotional safety—as a precursor to physical stability—emphasizes that feelings of psychological security reduce the likelihood of aggression and self-harm[25]. Nurses' recognition of cultural sensitivity as part of safety is consistent with calls for culturally competent psychiatric care, which fosters engagement and mitigates mistrust[26].

This broader conceptualization challenges narrow biomedical models of safety, which often prioritize environmental control and risk management. While such measures are critical, our findings suggest that in psychiatric wards, safety must also be relationally co-constructed between staff and patients. By integrating emotional and cultural components, the nurses in this study highlighted the need for safety frameworks that are tailored to the psychiatric context, rather than borrowed wholesale from general medical settings. Critically, this conceptualization challenges traditional biomedical safety models by integrating relational and cultural elements, as evidenced in another study[23], but our findings extend this by demonstrating how cultural stigma in Iran amplifies emotional vulnerabilities, thus highlighting the need for hybrid frameworks that blend global theories with local nuances. However, this broader view must be contextualized within our sample's Iranian setting, where cultural factors may heighten emotional emphasis; participant biases, such as recall of salient incidents, could overemphasize relational aspects, and contradictory views (e.g., one nurse prioritizing physical over emotional safety) suggest variability not fully captured here.

Staffing shortages emerged as a dominant barrier, echoing the extensive literature linking low nurse-to-patient ratios with adverse events in both psychiatric and acute care settings[27]. The participants described how understaffing not only delays responses and increases the risk of incidents but also erodes morale and contributes to burnout. This is consistent with the job demands–resources model, which posits that excessive workload without adequate support leads to emotional exhaustion and disengagement[28]. The reliance on agency or temporary staff was also noted as a safety risk, due to the loss of continuity and familiarity with patient histories—an issue particularly salient in psychiatric wards where individualized knowledge is crucial for risk assessment.

Similarly, this aligns with another research[29] but contributes analytically by revealing how understaffing creates systemic feedback loops—delayed responses heighten patient agitation, which in turn strains remaining staff—mechanisms underexplored in prior quantitative reviews. While consistent with global trends, our findings on staffing should consider contextual limitations, like Iran's public hospital constraints, and potential biases from predominantly female participants who may report higher burnout; deviant cases, such as nurses finding temporary staff innovative, indicate not all experiences align, warranting cautious generalization. Inadequate training was another recurrent theme, particularly in psychiatric-specific competencies such as de-escalation, trauma-informed care, and managing dual diagnoses. Previous research has similarly identified a gap between general nursing education and the specialized demands of psychiatric care[30]. The absence of ongoing training in emerging issues—such as substance use involving synthetic drugs—suggests a lag between clinical realities and educational provision, potentially compromising both staff confidence and patient outcomes.

Nurses' struggles with emerging issues, such as synthetic drug use, suggest that training must evolve to address contemporary clinical realities, ensuring staff are equipped to handle unpredictable patient behaviors. Our research takes this notion further by demonstrating that training deficiencies worsen the situation in underdeveloped areas, suggesting that a scenario where out-of-date skills result in reactive rather than proactive care is existing, which can be supported with JD-R theory[8] through targeted resource interventions. However, in our case, the resource scarcity may magnify these gaps; recruiting biases like self-selection of experienced nurses could lead to the development of critical views and opposing views (i.e. newer staff considering 'trial and error' as learning opportunities) making it clear that the need for nuanced interpretation. Patient-related factors, such as aggression or substance use, complicate safety efforts, consistent with literature on the unpredictability of mental health conditions[31, 32].This theme illustrates the need for dynamic risk assessment tools that account for fluctuating patient states. Environmental constraints, such as poor ward design, amplify risks by hindering observation and escalating patient tension, supporting evidence that therapeutic environments reduce aggression[10, 33]. The interplay of these barriers suggests that addressing one in isolation—such as improving staffing without updating training—may yield limited results, necessitating a systems-level approach.

Nurses identified effective communication, teamwork, supportive management, and comprehensive training as critical facilitators of safety. The emphasis on clear staff-to-staff handovers is consistent with research showing that communication breakdowns are a leading cause of sentinel events in healthcare[34]. In psychiatric wards, where patient status can shift rapidly, the timely exchange of nuanced information—such as triggers, behavioral patterns, or recent incidents—is especially vital.

Nurses' emphasis on involving families in communication highlights a relational approach that leverages external insights to enhance safety, a strategy underexplored in psychiatric safety literature. Teamwork and interdisciplinary collaboration, as described by nurses, enable rapid responses and shared accountability, resonating with research on interprofessional synergy in mental health care[35]. The participants' accounts of interdisciplinary synergy highlight the value of occupational therapists, social workers, and other allied health professionals in anticipating and addressing patient needs beyond the nursing scope.

This theme suggests that fostering team cohesion can serve as a buffer against staffing shortages, amplifying collective resilience. This engages with interprofessional model[35], contributing by showing how collaboration mitigates isolation in high-acuity wards, a systemic mechanism that enhances resilience beyond individual efforts. In our sample, interdisciplinary input was key, but biases from teaching hospital settings may idealize collaboration; opposing perspectives, such as siloed roles in acute wards, indicate contextual variations. Supportive management, characterized by visibility and a blame-free culture, aligns with transformational leadership models that enhance safety climates[36].

Nurses' accounts of managers securing resources, like weighted blankets, demonstrate how leadership directly influences safety by addressing environmental and patient needs. Our study critically extends transformational leadership theory[37] by demonstrating how visible support disrupts blame cultures, a mechanism that amplifies facilitators in under-resourced settings like Iran. While supportive in our findings, management styles vary; participant biases toward positive recall could soften critiques, and deviant cases of 'distant' leaders still yielding safety via protocols challenge overgeneralization. Comprehensive training, particularly scenario-based, builds competence and confidence, with evidence supporting simulation-based learning for high-stakes settings[38]. This facilitator underscores the potential for targeted education to bridge the training gap identified as a barrier, creating a synergy between themes.

Strategies for enhancing patient safety—improving staffing, enhancing training, modifying environments, and implementing evidence-based protocols—offer actionable solutions. These strategies are interconnected, addressing the barriers and building on the facilitators identified. For instance, improving staffing levels, as suggested by nurses, directly tackles understaffing while supporting teamwork by ensuring adequate resources[39]. Nurses' call for acuity-based staffing ratios highlights a precision approach, aligning resources with patient needs to prevent crises. Enhancing training through simulations and cross-disciplinary learning addresses skill gaps, complementing the facilitator of comprehensive training[40]. The suggestion of telepsychiatry skills reflects an innovative response to modern mental health care trends, ensuring relevance in a digital era. Environmental modifications, such as sensory rooms or better layouts, align with therapeutic design principles that reduce stress and aggression[41]. These changes not only address environmental constraints but also enhance the emotional safety emphasized in nurses' perceptions, creating a cohesive safety framework. Evidence-based protocols, tailored to local contexts, provide consistency while allowing flexibility, with post-incident debriefs fostering continuous improvement[42]. The emphasis on culturally sensitive protocols connects back to the theme of perceptions, ensuring that safety strategies resonate with diverse patient populations.

Finally, implementing evidence-based safety protocols was seen as essential for consistency and adaptability. The inclusion of post-incident debriefs mirrors recommendations from high-reliability organizations, where continuous learning from events is embedded into practice[42]. Importantly, participants emphasized the need for protocols to be tailored to the cultural and linguistic realities of their patient population, which reflects a culturally competent approach to safety. Our findings contribute by revealing adaptive protocols as a mechanism for cultural integration, building on high-reliability principles[43] to propose debriefs that evolve safety in diverse contexts. Tailored to Iran, these protocols address gaps, but participant biases toward evidence-based ideals may overlook practical hurdles; opposing views on rigidity vs. flexibility prevent overgeneralization.

Implications for Practice and Policy: The findings suggest that improving patient safety in psychiatric wards requires an integrated approach that addresses systemic,

environmental, and interpersonal domains. Policymakers and administrators should prioritize safe staffing models, fund targeted psychiatric training, and invest in therapeutic ward design. At the clinical level, fostering robust communication channels, interdisciplinary teamwork, and supportive leadership can strengthen the safety culture. Protocols should be evidence-based yet adaptable to local contexts, ensuring relevance and applicability. By critically integrating JD-R and psychological safety theories, this study contributes a mechanistic model for psychiatric safety, emphasizing relational-systemic interactions that inform global yet localized interventions.

Strengths and Limitations: A key strength of this study lies in its in-depth exploration of nurses' perspectives, offering rich, context-specific insights that quantitative studies may overlook. The diversity of participants in terms of experience, gender, and types of hospital wards enhance the breadth of their perspectives. However, the study is limited by its focus on a single professional group; perspectives from patients, families, and other mental health professionals could provide a more comprehensive understanding. Additionally, the qualitative design precludes generalization, although the findings may resonate with similar psychiatric settings.

Conclusion: This study contributes to the growing body of literature emphasizing that patient safety in psychiatric wards is a complex, multilayered construct. Nurses' insights reveal that safety encompasses physical, emotional, and cultural dimensions and is shaped by systemic, environmental, and patient-related factors. Addressing barriers—such as staffing shortages, training gaps, and environmental limitations—while leveraging facilitators such as communication, teamwork, and supportive leadership can enhance safety outcomes. Implementing the strategies proposed by nurses, particularly those that are evidence-based and context-sensitive, offers a roadmap for creating psychiatric care environments where both patients and staff can thrive.

Future studies could explore interventions derived from these findings, such as evaluating the impact of environmental modifications or targeted training programs on incident rates and patient outcomes. Comparative research across different cultural and healthcare contexts would also be valuable in identifying universally effective versus context-specific safety strategies.

Ethical Considerations

Ethical approval for the study was obtained from the Ethics Committee of Qazvin University of Medical Sciences (Approval No. IR.QUMS.REC.1404.096). All participants provided written informed consent before participation, after receiving a clear explanation of the study's objectives, procedures, potential risks, and their right to withdraw at any time without consequences. Confidentiality was strictly maintained by assigning codes to participants instead of names, storing recordings and transcripts on password-protected devices, and ensuring that all identifying details were removed from published reports. Only the research team had access to raw data, and all data handling complied with institutional and national regulations on research involving human participants.

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Conflict of Interest

The authors declare that there is no conflict of interest.

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