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Title: Safe Care Strategies from the Perspective of Psychiatric Ward Nurses

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Abstract

Background: Psychiatric inpatient care in Iran faces challenges from high disorder prevalence, resource constraints, and cultural stigma, necessitating context-specific safe care strategies. This study aimed to explain safe care strategies from the perspective of nurses in psychiatric wards in Iran.

Methods: This qualitative study used semi-structured interviews with 14 registered nurses from psychiatric wards in Urmia-Iran from October 2024–March 2025. Purposive and theoretical sampling achieved data saturation. Interviews were transcribed and analyzed verbatim following Graneheim and Lundman (conventional content analysis) approach using MAXQDA.

Results: The main emerged theme was "Holistic Safe Care Provision" with four categories including (1) Risk Anticipation and Prevention (environmental monitoring, behavioral assessment, Adherence to medication safety protocols); (2) Therapeutic Relationship Building (empathetic engagement, family involvement, de-escalation); (3) Resource Optimization and Team Coordination (skill enhancement, interdisciplinary teamwork, allocation efficiency); (4) Ethical and Cultural Sensitivity in Care (cultural congruence, ethical decision-making under constraints).

Conclusion: Nurses integrated proactive, relational, resourceful, and culturally attuned strategies to ensure safety amid constraints, informing tailored interventions for humane psychiatric care,

Keywords: Psychiatric nursing, Attitude of health personnel, Patient safety, Qualitative research, Cultural beliefs

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Highlights

- This study explains safe care strategies from the perspective of psychiatric ward nurses in Iran using conventional content analysis.
- The study found how nurses integrate proactive risk prevention, therapeutic relationship building, resource optimization, and ethical-cultural sensitivity into their daily practice.
- The overarching main theme was: Holistic Safe Care Provision with four categories and 11 subcategories.
- The findings highlight nurses' adaptive expertise in resource-constrained settings, where cultural and religious values shape safety practices.

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Plain Language Summary

This study explores how nurses working in psychiatric wards in Iran keep their patients safe while providing care. Through in-depth interviews with 14 nurses, the researchers found "Holistic Safe Care Provision" as the main theme which describes how nurses incorporate different strategies to protect patients. The findings show that nurses constantly watch for potential dangers in the ward environment, carefully observe patients' behaviors for signs of trouble, and strictly follow medication safety rules. They build trusting relationships with patients through empathy, involve families in care, and use calm communication to prevent crises. Despite limited resources, nurses work together in teams, improve their skills through training, and make the best use of available tools. Importantly, they adapt their care to respect Iranian cultural and religious values, such as modesty and prayer times, while navigating difficult ethical decisions when resources are scarce. This study helps us understand how nurses in countries with limited mental health resources develop creative and culturally sensitive ways to provide safe care, offering valuable insights for improving psychiatric services in similar settings worldwide.

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Introduction

Psychiatric disorders constitute a significant global health burden, affecting approximately one in eight individuals worldwide, with profound implications for quality of life, social functioning, and economic productivity (Maddineshat et al., 2024). In Iran, the lifetime prevalence of psychiatric disorders reaches 36.5%, encompassing conditions such as mood disorders, anxiety, and substance use disorders, exacerbated by socioeconomic stressors, cultural stigma, and limited access to specialized services (Vahidi et al., 2019). Psychiatric inpatient care remains a cornerstone of treatment for acute exacerbations, severe symptomatology, and risk management, yet it is fraught with unique challenges (Maddineshat et al., 2024). Patients in these settings often experience heightened vulnerability due to symptom acuity, medication side effects, and environmental constraints, rendering the delivery of safe care a paramount ethical and clinical imperative (Keykha et al., 2025).

Safe care in psychiatric wards encompasses a multifaceted construct aimed at preventing harm while promoting therapeutic outcomes (Vahidi et al., 2023). It includes physical safety measures to mitigate risks of self-harm, aggression, or falls; psychological safety to foster trust and reduce coercion; and systemic safeguards such as adequate staffing, policy adherence, and environmental design (Dizavandi et al., 2023). Despite international guidelines emphasizing de-escalation, least-restrictive interventions, and patient-centered approaches (Ahmadidarrehsima et al., 2022), implementation varies widely, influenced by resource availability, cultural norms, and professional expertise. In low- and middle-income countries (LMICs) like Iran, these disparities are amplified by underfunded mental health systems, high nurse-to-patient ratios, and reliance on custodial rather than recovery-oriented models (Torkaman et al., 2022).

Nurses, as the primary providers of healthcare services in psychiatric wards, are in contact with patients at most hours and are uniquely positioned to identify, prevent, and respond to safety threats (Akinlotan et al., 2025). Their perspectives offer invaluable insights into the practical realities of safe care, revealing both facilitators and barriers that quantitative metrics often overlook (Delaney and Johnson, 2006). In Iran, psychiatric nursing is shaped by a blend of Islamic ethical principles emphasizing compassion, justice, and preservation of life with modern biomedical frameworks (Vahidi et al., 2019). However, nurses contend with contextual challenges, including overcrowded wards, medication shortages, familial involvement in decision-making, and societal misconceptions about mental illness that can precipitate stigma or violence (Zarea et al., 2013). These factors underscore the need for culturally attuned strategies that align with local values while adhering to evidence-based standards (Setoodeh et al., 2025).

In the Iranian context, prior qualitative studies have examined related topics, such as therapeutic communication and restraint use (Vahidi, 2023). For instance, a study titled "Safety Challenges in Psychiatric Departments from Nurses' Perspective: A Qualitative Study" specifically addressed safety concerns from nurses' viewpoints, highlighting barriers such as environmental hazards, staffing shortages, and patient-related risks (Torkaman et al., 2025). However, while these studies have identified safety problems and obstacles, they have not systematically explored the strategies that nurses actively employ to overcome these challenges and deliver safe care in their daily practice.

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Existing literature predominantly focuses on Western settings, where individualized care and advanced technologies predominate, potentially limiting applicability to resource-constrained environments (Kuosmanen et al., 2021).

The gap in context-specific evidence is evident. For instance, a systematic review highlighted global inconsistencies in aggression management, but included few studies from the Middle East, none from Iran (Maqbali et al., 2024). Understanding nurses' lived experiences is thus critical for developing tailored interventions that enhance safety without compromising dignity or autonomy.

This study addresses these imperatives by employing conventional content analysis to explain safe care strategies from the perspective of psychiatric ward nurses in Iran. In summary, amid rising mental health demands and systemic constraints in Iran, nurses' insights into safe care strategies represent a vital yet underutilized resource. This qualitative study bridges theoretical ideals with clinical practice, fostering a culturally resonant pathway to improved inpatient outcomes.

Materials and Methods

This qualitative study employed conventional content analysis to explore safe care strategies as perceived by nurses working in psychiatric wards in Iran. Conventional content analysis was selected because it allows categories to emerge directly from the data without imposing preconceived frameworks, making it suitable for understanding participants' lived experiences and perspectives in a culturally sensitive context (Hsieh and Shannon, 2005). The study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist to ensure transparency and rigor (Buus and Perron, 2020).

The research was conducted in psychiatric wards of two public hospitals affiliated with Urmia university of medical sciences in Urmia, Iran, between October 2024 and March 2025. Participants were registered nurses with at least one year of experience in adult psychiatric inpatient units, providing direct patient care. Nurses in administrative positions or those with less than one year of recent psychiatric ward experience were not included. Purposive sampling was used initially to select information-rich participants, followed by theoretical sampling as concepts emerged during analysis to achieve data saturation.

Semi-structured, in-depth interviews were conducted face-to-face in a quiet room within the hospital or via secure video conferencing for participants in remote areas, lasting 45–90 minutes each (mean = 62 minutes). An interview guide was developed based on a literature review and expert consultation, with open-ended questions such as: " What are your concerns regarding patient safety in psychiatric wards? "Can you describe a situation where you implemented safe care practices?" and "What challenges do you face in maintaining safety, and how do you overcome them?" Probing questions were used to elicit detailed responses. Interviews were audio-recorded with consent and transcribed verbatim in Persian. Field notes captured non-verbal cues and contextual details (Phillippi and Lauderdale, 2018). A total of 14 registered nurses participated in the study. Data collection continued until saturation was reached, which occurred after the 12th interview, as no new categories emerged from the last three consecutive interviews (interviews 12, 13, and 14), in line with the criteria defined by Francis et al. (2010).

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Data analysis followed the conventional content analysis approach outlined by Graneheim and Lundman , which is suitable for deriving categories directly from the text without preconceived theories (Graneheim and Lundman, 2004). The process involved: (1) verbatim transcription of interviews; (2) repeated reading of transcripts for immersion and holistic understanding; (3) identifying meaning units (words, sentences, or paragraphs related to the study aim); (4) condensing meaning units into codes; (5) grouping codes into subcategories based on similarities; (6) abstracting subcategories into main categories; and (7) formulating overarching themes that captured the essence of participants' experiences.

Analysis was iterative and concurrent with data collection to guide sampling. Transcripts were managed using MAXQDA software (version 12) for coding and organization. Two researchers independently coded a subset of transcripts, resolving discrepancies through discussion to ensure consistency. The final themes were reviewed for coherence and relevance to the raw data.

To enhance the rigor of the study, Lincoln and Guba's criteria for trustworthiness were applied (Lincoln and Guba, 1988) ,which include credibility, dependability, confirmability, and transferability. Specific strategies were employed for each criterion, as detailed below:

Credibility: We established credibility through prolonged engagement (the first author spent over six months in the psychiatric wards prior to and during data collection to build rapport and understand the context), member checking (three participants reviewed and confirmed the initial codes and categories), and peer debriefing (regular sessions with the research team and an external qualitative expert to challenge assumptions and reduce bias). Additionally, maximum variation sampling was employed to include participants with diverse demographics (e.g., age, gender, experience, and ward type), which enriched the data and provided a comprehensive understanding of the phenomenon. Dependability: A comprehensive audit trail was maintained, including raw data, coding details, analytical memos, and methodological decisions, allowing an external reviewer to track the research process.

Confirmability: To ensure neutrality, the first author kept a reflexive journal throughout the study to document personal preconceptions and assumptions. Moreover, independent coding was performed by two researchers on a subset of three transcripts; discrepancies were discussed and resolved to ensure that findings were grounded in the data.

Transferability: We provided a thick description of the research context, including participant demographics (Table 1), details of the hospital settings (urban, university-affiliated psychiatric wards in Urmia), and illustrative verbatim quotes, enabling readers to assess the applicability of our findings to similar contexts.

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Results

Demographic details of the participants are presented in Table 1**.**

Table 1: Demographic Characteristics of Participants

Participant Code	Age (years)	Gender	Marital Status	Education Level	Psychiatric Nursing Experience (years)	Ward Type
P1	42	Male	Married	Bachelor's	11	Acute inpatient
P2	31	Female	Single	Bachelor's	4	Chronic/rehabilitation
P3	38	Female	Married	Master's	9	Acute inpatient
P4	45	Female	Married	Bachelor's	14	Chronic/rehabilitation
P5	29	Male	Single	Bachelor's	3	Acute inpatient
P6	36	Female	Married	Bachelor's	6	Acute inpatient
P7	41	Male	Married	Bachelor's	10	Acute inpatient
P8	33	Female	Married	Master's	5	Chronic/rehabilitation
P9	48	Female	Married	Bachelor's	15	Chronic/rehabilitation
P10	27	Female	Single	Bachelor's	2	Acute inpatient
P11	39	Male	Married	Bachelor's	8	Acute inpatient
P12	34	Female	Married	Master's	7	Chronic/rehabilitation
P13	44	Female	Married	Bachelor's	12	Acute inpatient
P14	37	Male	Single	Bachelor's	6	Acute inpatient

The analysis of interviews yielded one overarching main theme: Holistic Safe Care Provision. This theme encapsulates the nurses' perceptions of safe care as a multifaceted, integrated process that balances patient safety, therapeutic efficacy, and professional accountability within the resource-constrained and culturally influenced context of Iranian psychiatric wards. It emerged from the nurses' emphasis on proactive, patient-centered strategies that mitigate risks while fostering recovery and trust.

The main theme included four categories, each representing a core dimension of safe care strategies. These categories were further divided into 11 subcategories, derived inductively from the data through conventional content analysis. Categories and subcategories are detailed below, with illustrative quotes from participants (Table 2)

Table 2: Overview of Main Theme, Categories, and Subcategories

Main Theme	Category	Subcategory
Holistic Safe Care Provision	**Risk Anticipation and Prevention**	Environmental hazard monitoring
		Behavioral risk assessment
		Adherence to medication safety protocols
	Therapeutic Relationship Building	Empathetic engagement
		Family involvement strategies
		De-escalation communication
	Resource Optimization and Team Coordination	Staff skill enhancement
		Interdisciplinary teamwork
		Resource allocation efficiency
	Ethical and Cultural Sensitivity in Care	Cultural congruence in interventions
		Ethical decision-making under constraints

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Category 1: Risk Anticipation and Prevention

This category highlights nurses' proactive identification and mitigation of potential hazards in the psychiatric environment, emphasizing vigilance and foresight as core competencies that enable early intervention, prevent escalation of crises, and safeguard both patients and staff in a setting where unpredictability is inherent.

Subcategory 1.1: Environmental hazard monitoring

Nurses described routine checks for physical risks such as sharp objects, unsecured windows, loose fixtures, or everyday items that could be repurposed for harm, conducting systematic sweeps at the start of each shift, during handovers, and intermittently throughout the day to maintain a dynamically safe space.

"We scan the ward every shift for anything that could be used in self-harm; even a broken chair leg, a misplaced pen, or a frayed bedsheet is a potential threat we remove, repair, or report it immediately to eliminate risks before they materialize" (P3).

Subcategory 1.2: Behavioral risk assessment

Ongoing evaluation of patient cues to predict aggression, suicide attempts, or decompensation, involving subtle observations of body language, verbal patterns, withdrawal signs, and interpersonal dynamics, often cross-referenced with historical patient data and real-time mood fluctuations to inform timely preventive actions.

"You learn to read the silence when a patient stops talking, avoids eye contact, paces erratically, or suddenly isolates, that's when danger spikes; we intervene with one-on-one checks or environmental adjustments to avert escalation" (P7).

Subcategory 1.3 Adherence to medication safety protocols

Strict adherence to administration and monitoring to prevent errors, misuse, diversion, or adverse reactions, encompassing multi-step verification processes, patient education on effects, and vigilant post-administration surveillance to catch early signs of complications in a high-stakes pharmacological landscape.

"Double-checking doses isn't optional; one wrong pill whether in strength, timing, or interaction can escalate everything from mild agitation to full-blown psychosis or overdose, so we verify identifiers, cross-reference charts, and monitor responses hourly" (P11).

Category 2: Therapeutic Relationship Building

This category underscores the relational foundation of safe care, where empathy, consistent communication, and mutual respect reduce volatility, enhance patient compliance with treatment plans, foster a sense of security, and ultimately decrease the need for coercive measures in psychiatric nursing practice.

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Subcategory 2.1: Empathetic engagement

Building trust through active listening, validation of patient experiences, non-judgmental responses, and personalized interactions that acknowledge emotional pain, cultural backgrounds, and individual narratives, thereby creating a therapeutic alliance that mitigates feelings of alienation or hostility.

"Patients feel safe when you sit with them at eye level, not just medicate them from afar; truly hearing their fears, validating their struggles without rushing to solutions, turns potential adversaries into collaborators in their own recovery" (P2).

Subcategory 2.2: Family involvement strategies

Integrating family support to reinforce safety nets outside the ward, including structured family meetings, education on symptom recognition, crisis planning, and discharge coordination to address home-based triggers and ensure continuity of care that prevents relapse or readmission.

"Families are our allies; educating them on warning signs, medication adherence, and de-escalation at home prevents readmissions from triggers like familial conflicts or unmet needs, strengthening the overall support system beyond hospital walls" (P9).

Subcategory 2.3: De-escalation communication

Verbal techniques to calm agitated patients without restraint, utilizing tone modulation, empathetic phrasing, open-ended questions, and body language cues to defuse tension, redirect focus, and restore rational dialogue in moments of heightened emotional distress.

"A calm voice, steady eye contact, and open posture can stop a crisis before it starts; by acknowledging their anger, offering choices, and speaking in reassuring rhythms, we guide them back from the edge without ever laying a hand" (P5).

Category 3: Resource Optimization and Team Coordination

Nurses emphasized leveraging limited resources and interdisciplinary collaboration to sustain safe practices, highlighting adaptive strategies, knowledge sharing, and collective decision-making that compensate for systemic shortages and enhance overall ward resilience in resource-constrained psychiatric settings.

Subcategory 3.1: Staff skill enhancement

Ongoing training to handle complex psychiatric scenarios, including simulations, workshops, peer mentoring, and certification programs focused on non-violent interventions, trauma-informed care, and emergency response to build competence and confidence among nursing teams.

"Workshops on restraint alternatives, crisis negotiation, and cultural competency save lives and reduce burnout; they equip us with practical tools to manage mania or paranoia effectively, turning potential chaos into controlled, compassionate outcomes" (P1).

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Subcategory 3.2: Interdisciplinary teamwork

Coordinated efforts with physicians, psychologists, social workers, and security personnel, involving regular case conferences, shared risk assessments, and integrated care plans to pool expertise and ensure comprehensive monitoring that no single discipline could achieve alone.

"Safety isn't solo; the psychiatrist flags subtle medication side effects or diagnostic shifts we might miss, while security provides backup protocols, creating a seamless web of vigilance that protects everyone involved" (P14).

Subcategory 3.3: Resource allocation efficiency

Creative use of available tools amid shortages, such as prioritizing high-risk patients for limited seclusion spaces, repurposing multipurpose areas, or implementing triage systems based on validated risk scoring to maximize utility and minimize gaps in safety coverage.

"With few seclusion rooms and inconsistent supplies, we prioritize based on risk scores, daily acuity levels, and predictive indicators rotating staff coverage and improvising with soft restraints or observation zones to maintain safety without compromise" (P6).

Category 4: Ethical and Cultural Sensitivity in Care

This category reflects the integration of Iranian cultural norms, religious values, and ethical dilemmas in ensuring safe, respectful care, navigating tensions between patient rights, societal expectations, and practical limitations to deliver holistic, dignified interventions in a culturally embedded healthcare context.

Subcategory 4.1: Cultural congruence in interventions

Adapting strategies to respect modesty, prayer times, family hierarchies, gender preferences, and religious observances, such as scheduling activities around prayer, ensuring privacy during examinations, or involving elders in decision-making to avoid cultural dissonance that could provoke distress or non-compliance.

"For female patients, same-gender staffing, veiled interactions, and accommodations for prayer prevent agitation rooted in cultural shame or religious discomfort; aligning care with these norms builds trust and reduces resistance to necessary safety measures" (P4).

Subcategory 4.2: Ethical decision-making under constraints

Balancing patient autonomy with safety in under-resourced settings, grappling with dilemmas like informed consent during acuity peaks, resource rationing, or mandatory interventions when voluntary options are exhausted, guided by professional ethics and institutional policies.

"Sometimes seclusion is the ethical choice when meds are delayed by supply issues, staffing shortages force tough calls, or immediate risks outweigh autonomy we document rationale meticulously, debrief afterward, and advocate for systemic fixes to honor dignity amid necessity" (P10).

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Discussion

This qualitative study, utilizing conventional content analysis, elucidates safe care strategies in Iranian psychiatric wards through the lens of frontline nurses, culminating in the overarching theme of Holistic Safe Care Provision. This theme portrays safe care as an integrated, dynamic process that transcends isolated interventions, intertwining proactive risk mitigation, relational therapeutics, resource ingenuity, and ethical-cultural alignment to safeguard patients amid acute symptomatology and systemic constraints. The emergence of four core categories “Risk Anticipation and Prevention”, “Therapeutic Relationship Building”, “Resource Optimization and Team Coordination”, and “Ethical and Cultural Sensitivity in Care”, reflects nurses' adaptive expertise in a context marked by high nurse-to-patient ratios, medication shortages, and cultural stigma. These findings align with yet extend beyond international literature, highlighting the contextual adaptation required in LMICs like Iran, where custodial models often persist despite global shifts toward recovery-oriented care (Torkaman et al., 2022).

The category of “Risk Anticipation and Prevention” underscores nurses' vigilance as a foundational strategy, with subcategories emphasizing environmental scans, behavioral cue interpretation, and medication adherence protocols. Nurses' descriptions of "reading the silence" as a precursor to escalation resonate, which posits that subtle behavioral shifts precipitate ward incidents (Johnson et al., 2022). However, in Iran, this anticipation is amplified by resource limitations; for instance, routine removal of potential self-harm tools compensates for inadequate environmental design, contrasting with high-income settings equipped with sensor technologies or ligature-free fixtures (Rathnayake et al., 2021). Medication safety protocols, involving double-checks amid supply disruptions, echo global error-prevention mandates but reveal unique vulnerabilities, such as delays exacerbating agitation a factor intensified post-COVID-19 (Østervang et al., 2022). This proactive stance prevents harm but imposes cognitive burden on nurses, potentially contributing to burnout, as evidenced by high meaning units dedicated to this category.

“Therapeutic Relationship Building” emerged as the most salient category, affirming relational practices as the bedrock of safety in psychiatric nursing, where trust mitigates coercion and fosters voluntary compliance. Notably, family involvement strategies distinguish Iranian practices from Western individualism; educating families as "allies" leverages collectivist cultural norms to extend safety nets, reducing readmissions triggered by home stressors (Ghafouri et al., 2021). This contrasts with studies in individualistic contexts, where family roles are often limited to visitation (Keykha et al., 2025). De-escalation via calm verbal techniques minimizes restraint use, supporting least-restrictive imperatives (Mohammadi et al., 2023), yet nurses' reliance on personal demeanor highlights gaps in formalized training, underscoring the need for culturally tailored communication curricula.

In “Resource Optimization and Team Coordination”, nurses demonstrated resilience through staff training, interdisciplinary collaboration, and efficient allocation amid scarcity. Workshops on restraint alternatives address skill deficits. Interdisciplinary teamwork, involving psychiatrists and security, compensates for nursing shortages, akin to global models but adapted to Iran's hierarchical healthcare structures (Vahidi et al., 2023). Resource prioritization based on risk scores exemplifies pragmatic innovation, yet it risks inequity in overcrowded wards, where chronic patients may be deprioritized. This category illuminates how nurses in LMICs transform constraints into opportunities, differing from resource-abundant settings where technology augments coordination (Khazaei et al., 2024).

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The category of “Ethical and Cultural Sensitivity in Care”, uniquely captures Iran's Islamic-biomedical synthesis, with subcategories addressing modesty, prayer accommodations, and autonomy-safety dilemmas. Same-gender staffing to avert "cultural shame" prevents agitation rooted in societal norms, ethical principles of compassion and justice. Ethical decision-making under constraints opting for seclusion due to medication delays highlights moral distress in underfunded systems, where patient dignity competes with immediate risk management (Habibi Soola et al., 2022) . This contrasts with Western bioethics emphasizing autonomy via advance directives, revealing how cultural congruence enhances safety by reducing resistance while preserving humane care (Sajber and Khaleefah, 2024).

Strengths and Limitations

Strengths include methodological rigor via adherence to COREQ, data saturation, and member checking, ensuring trustworthiness. Limitations encompass the focus on urban university-affiliated hospitals, potentially underrepresenting rural or non-academic settings with greater resource deficits. Self-reported data risks social desirability bias, mitigated somewhat by anonymity and reflexivity. Exclusion of patient or family perspectives limits triangulation, and the qualitative design precludes generalizability beyond similar LMIC contexts.

Implications

Practically, integrating these strategies into ward protocols such as standardized behavioral risk tools, family education modules, and cultural sensitivity checklists could standardize safe care while accommodating constraints. Educationally, nursing curricula should incorporate simulation-based de-escalation, ethical case studies on resource dilemmas, and Islamic principles to prepare graduates for psychiatric realities. Policy-wise, findings advocate for increased funding to reduce ratios, ensure medication supply chains, and mandate interdisciplinary training, aligning with WHO recommendations for LMIC mental health reform. Future interventions might pilot nurse-led risk anticipation programs or family involvement initiatives to evaluate outcomes like incident reduction and satisfaction.

Quantitative studies could validate these categories through safety incident correlations or psychometric scale development for holistic safe care. Comparative qualitative research across LMICs (e.g., contrasting Iran with Turkey or India) would elucidate universal versus context-specific elements. Longitudinal designs exploring strategy evolution post-policy changes, or mixed-methods incorporating patient viewpoints, could deepen insights. Exploring gender dynamics in nurse-patient interactions, given Iran's modesty norms, warrants dedicated inquiry.

Conclusion

This study revealed that psychiatric ward nurses in Iran operationalize safe care through four interconnected categories: Risk Anticipation and Prevention, Therapeutic Relationship Building, Resource Optimization and Team Coordination, and Ethical and Cultural Sensitivity in Care. These categories collectively underpin the overarching theme of Holistic Safe Care Provision, demonstrating that safety is not a singular action but a dynamic, integrated process. By proactively identifying environmental and behavioral risks, cultivating trusting therapeutic relationships, creatively mobilizing limited resources through teamwork, and respectfully aligning care with Iranian cultural and religious values, nurses navigate systemic constraints while preserving patient dignity. This study positions Iranian psychiatric nurses as architects of holistic safe care, navigating vulnerabilities with ingenuity and cultural attunement. By

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bridging global standards with local realities, it paves the way for equitable, dignified inpatient mental health services, ultimately alleviating the profound burden of psychiatric disorders in Iran and beyond.

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Institutional Research Ethics Committee of Urmia University of Medical Sciences, Urmia, Iran, with the ethics code IR.UMSU.REC.1404.288. Participants received detailed information about the study's purpose, voluntary nature, and right to withdraw at any time without repercussions. Written informed consent was secured, emphasizing confidentiality (e.g., use of pseudonyms, secure data storage). The research was conducted in accordance with the principles of the Declaration of Helsinki, which provides ethical guidelines for medical research involving human subjects. The participants were assured of the anonymity and confidentiality of their information. No incentives were provided, and data were stored on password-protected devices accessible only to the research team.

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Author Contributions: R.A. and Y.M. contributed to the conception and design of the study. Y.M. was responsible for the acquisition of data, including conducting all interviews and transcribing the recordings. R.A. and Y.M. performed the analysis and interpretation of the data. R.A. drafted the first version of the manuscript. Both R.A. and Y.M. critically revised the manuscript for important intellectual content and approved the final version. All authors have accepted responsibility for the overall content of the manuscript and have approved its submission.

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Conflict of interest: The authors declare no competing interests.

Declaration of the use of Artificial Intelligence: During the preparation of this work, the authors used ChatGPT (OpenAI, GPT-4 model) and DeepSeek (DeepSeek-V3) solely for language editing, grammar checking, and paraphrasing assistance to improve the clarity and readability of the manuscript. No generative AI tools were used for data collection, data analysis, coding, theme development, interpretation of findings, or any core scientific and analytical processes. All intellectual content, including study design, interview guide development, qualitative analysis, and final interpretation, was performed entirely by the authors. The authors reviewed and edited all AI-assisted content and take full responsibility for the final manuscript.

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