Implementation of Safewards
across three inpatient mental health units

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Queensland University of Technology

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We acknowledge the traditional custodians of the land on which we meet today and pay respect to Elders past, present and emerging.

We also extend that respect to other Aboriginal and/or Torres Strait Islanders who are joining us here today.

David R Horton, creator, © Aboriginal Studies Press, AIATSIS and Auslig/Sinclair, Knight, Merz, 1996.
View an interactive version of the AIATSIS map [www.abc.net.au/indigenous/map/](http://www.abc.net.au/indigenous/map/)

Header Artwork produced for Queensland Health by Gilimbaa
Research team

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- Clinical Associate Professor Michael Kilshaw, RN, MMHN
- Professor Debra Anderson, RN, BA, GDipNursStuds, MNurse, Ph.D.
- Dr Niall Higgins, RN, GDipeH, Ph.D.
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Ethics committees
Royal Brisbane & Women’s Hospital HREC – HREC/15/QRBW/100
Queensland University of Technology HREC - 1500000532

Governance committees
Royal Brisbane & Women’s Hospital
The Prince Charles Hospital
Ipswich Hospital

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Background

- History of 18mth-2yr cyclical aggressive incidents
  - Seclusion rate per 1000 days is unacceptably high
  - Associated with unauthorised leave occurrences
  - Leads to self-harm and suicide

- Structured risk assessment cannot in itself change the outcome of aggression

- Must be accompanied with risk management strategies
  - Mediate between the risk assessment and aggression

# Retrospective Chart audit

<table>
<thead>
<tr>
<th>Gender</th>
<th>n</th>
<th>%</th>
<th>Mean age</th>
<th>Min age</th>
<th>Max age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>49</td>
<td>57</td>
<td>39</td>
<td>19</td>
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<tr>
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<td>35</td>
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<td>18</td>
<td>69</td>
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<tr>
<td>Transgender</td>
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<td>2</td>
<td>25</td>
<td>20</td>
<td>29</td>
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</table>

N=86
### Incidents

<table>
<thead>
<tr>
<th>Gender</th>
<th>n</th>
<th>% all admissions</th>
<th>% involved in an incident</th>
<th>Mean age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>11</td>
<td>13</td>
<td>69</td>
<td>36</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>6</td>
<td>31</td>
<td>23</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16</td>
<td>19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Organisational database (PRIME) = 9
### Analysis

**Risk assessment of Aggression upon admission**

<table>
<thead>
<tr>
<th>Patient involved in an Incident</th>
<th>Yes (High)</th>
<th>No (Low)</th>
<th>Total</th>
<th>Sensitivity = 60%</th>
<th>Specificity = 84%</th>
<th>PPV = 30%</th>
<th>NPV = 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>36</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>10</td>
<td>38</td>
<td>48</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Already known
  - Clinical judgement not a reliable predictor of risk
• Disrupts the therapeutic milieu of Unit

• Makes some patients fearful
  – increase in absconding, self-harming...

• Makes some staff fearful
  – increase in injury, sick leave

Cultural practice change

• Any intervention that brings about change in practice is likely to contribute towards reducing the rates of conflict and containment

• Two clear routes
  – education/training
  – clinical supervision

• An alternative approach is to focus on the identified flashpoints
  – finding better ways to manage them
Safewards

• A model of Mental Health Nursing care
  – Developed in UK by Len Bowers

• Organised into six domains
  – Ten interventions aimed at reducing aggression

• Provides an explanatory framework for conflict and containment
  – Queensland Inpatient units at RBWH, TPCH and Ipswich Hospital
  – SHMRU’s at Caboolture, TPCH and The Park (9x wards in total)

• Flashpoints are social locations on the ward that are most likely to trigger conflict

• Small changes to routines and usual practices have the capacity to make large impacts on rates of conflict and thus containment
  – conflict events were reduced by 15% (95% CI 5.6–23.7%) relative to the control intervention
  – The rate of containment events for the experimental intervention was reduced by 26.4% (95% CI 9.9–34.3%)

Sources for flashpoints that can trigger conflict and containment

1. Patient community
2. Patient characteristics
3. The regulatory framework
4. The staff team
5. The physical environment; and
6. Outside hospital

Safewards model

- **Staff modifiers**
  - **Patient modifiers**
    - **Originating domains**
      - **Flashpoints**
        - **Conflict**
          - **Containment**

Safewards program

1. **Establish clear mutual expectations**: Ward staff hold regular meetings with patients to discuss expectations of each other’s behaviour. Final set of expectations are printed on a poster and displayed on the ward for new patients and staff who are working temporarily on the ward for the first time.

2. **Mutual help meeting**: Unit to hold a patient meeting each morning to identify ways that patients can help each other during the ensuing 24-48 hours.

3. **Positive Words**: Staff are encouraged to say something positive about the people they were handing over to staff coming on duty.

4. **Soft words**: About 100 statements, 1 or 2 sentences long are provided to staff for advice on how to speak to patients around 3 ‘flashpoints’; (i) When staff have to say ‘no’ to a patient, (ii) when staff have to ask a patient to do something that they don’t want to do, (iii) when staff have to ask the patient to stop doing something that they are doing.

5. **Talk down**: Staff are taught a process for de-escalation and how to integrate this into practice.

6. **Calm down methods**: Staff are taught specific activities to assist patients to calm down when a patient is noticed to be tense and/or agitated.

7. **Bad news Mitigation**: Staff are taught specific techniques to assist then in delivering ‘bad’ news to a patient.

8. **Know each other**: Staff provide non-controversial information about themselves (hobbies, interests, etc). This is made available to patients and form the basis for better interactions with staff.

9. **Reassurance**: Following the occurrence of an adverse / anxiety provoking incident on the Unit, staff speak to other patients individually or in groups to provide information on what has happened and reassure patients.

10. **Discharge Messages**: On the day of their discharge, consumers are asked to write a brief card for display on a special notice board. The cards states what they liked about their stay, the staff and provides – aim to reduce conflict from hopelessness.
Process
Conflict and Containment

- Wide variation in conflict between units
  - aggression, self-harm, absconding, medication refusal

- Wide variation in containment measures between units
  - seclusion, prn, manual restraint, special observations

- Staff have a key role in influencing levels of conflict and or containment
Process

Steering committees

• Royal Brisbane & Women’s Hospital – Chair Mr. Nathan Dart
• The Prince Charles Hospital – Chair Mr. Michael Kilshaw
• Ipswich Hospital – Chair Assoc. Prof. Thomas Meehan

Implementation Support

• Nurse Educators
  • RBWH, TPCH & Ipswich
• 5x One-day training events
  • 1 at RBWH; 2 at TPCH; 1 at The Park; 1 at Ipswich
• Research Assistants
  • 2 at RBWH; 1 at TPCH; and 1 at Ipswich
Safewards Program

A program designed to increase safety on the wards for staff and consumers through the use of 10 key interventions

Clear and Mutual Expectations
A set of clear expectations that are formulated by both staff and consumers regarding expected behaviour.

Soft Words
To assist staff and consumers with times associated with high stress.

Talk Down
A de-escalation process that draws together basic and advanced techniques and assembles them into a meaningful picture for routine use.

Positive Words
When handing over, staff should say something positive regarding the consumer. If negative behaviour is reported for that shift a psychological explanation should be provided.

Bad News Mitigation
Bad news can be a precursor to impulse behaviours on the ward. When expressing bad news to anyone, staff should be observant for signs of distress and provide an appropriate intervention if required.

Know Each Other
Each member of staff will provide non-confrontational information about themselves that they are happy to be communicated to others.

Mutual Help Meeting
Three times a week a meeting is conducted for the purpose of providing ideas on how to best support each other.

Calm Down Methods
This includes the construction of a specific environment that proves the opportunity for low stimulus and time out.

Reassurance
Following the occurrence of a potentially anxiety provoking incident on ward all those associated should be approached to ask them for their understanding of what has happened, what effect is has had on them and to give them an explanation as to what has happened.

Discharge Messages
On the day of discharge, each consumer is to be asked if they would write a card to include what would be their most positive and helpful piece of advice for new consumers. The card will then be hung on the discharge message tree.
Process

• Initially resistant before training
  – Rule based practice/ Custodial nursing
  – Consumer group perceived as too psychotic
  – 30+ years of experience difficult to change
  – Only for junior staff

• Change post training
  – Peer pressure during training events to adopt Safewards
  – Management support (NUMs and CNs)
  – Champions and leaders identified
  – Emphasis on role modelling from experienced staff
Knowledge translation

• Implementation support
  – Crucial for NUM to adopt Safewards
  – Essential to support NUMs at executive level
  – Educators vital to guide Champions
    • Champions mentor leaders

• Resource support
  – One-day training events well attended
    • Booklets, websites etc
  – Safewards related materials
    • Posters, etc.
1. Clear and Mutual Expectations

• Ward staff to engage with patients
  – hold meetings and discuss what are the expectations of each other’s behaviour

• Impact
  – Nurse Educators held multiple meetings
    • Staff, consumers, carers
  – Occupation Therapist supportive
    • Outcomes form therapy related artwork
Clear Mutual Expectations
We are all equal human beings living in a close community environment

These are some of the expectations that we have of each other:

- Treat each other as we ourselves would like to be treated
- Remember that we are all unique and individual
- Try to be patient with each other
- Everyone will be welcomed and orientated to the ward
- Staff will introduce themselves to patients each shift
- Make an effort to connect with each other with kindness and compassion
- We will all do our best to look after our personal hygiene and presentation
- We will be mindful of ourselves and the people around us
- Respect each other’s personal space and privacy
- Clean up after ourselves
- Respect each other’s belongings
- It’s always okay to ask for help
- We are not here to judge each other
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2. Soft Words

• Primarily in 3 Flashpoints
  – When say no to a patient request
  – ask to do something that they didn’t want to do
  – ask to stop doing something that they were doing

• Impact
  – Slight tweak in language from English to Australian
    – Nurse Educators & Psychology staff assisted
  – Senior staff comfortable with & role model well
    – Safewards framework emphasised if inadvertent language observed
Soft Words Interventions

1. Respectful and Polite:
   This theme focuses on being respectful and polite towards consumers both verbally and non-verbally showing genuine and empathetic respect. “Treat others as you would like to be treated”

2. Turning down a request:
   This theme looks at how staff turn down requests from consumers. Reminding staff to reflect on consumers requests, their reasons behind it, it focuses on justification of the response and how this is conveyed to the consumer.

Soft Words Themes

3. Asking a consumer to do something:
   This theme explores how staff request consumers to do something, the way in which the request is made, how appropriate the request is for that consumer and how flexible staff are in their approach.

4. Asking a consumer to stop doing something:
   Getting nurses to be clear on why a consumer should stop and prompts nurses to be flexible.
2016 Melbourne Cup
4. Positive Words

- Every handover
  - say something positive about the people they are handing over

- Impact
  - Greatest area of noticeable change
  - Medical staff supportive
  - Nurse Educators & Psychologists facilitated implementation
6. Know Each Other

• Each member of staff will provide non-controversial information about themselves that they are happy to be communicated to consumers.

• Impact
  – Some resistance with staff not wishing consumers to know too much about themselves
  – Missing the point of the intent as an ice-breaker
  – Some areas placed photos on the wall
7. Mutual Help Meeting

- Wards to conduct meetings
  - at a minimum of three times a week

- Impact
  - Well facilitated by staff
    - Nursing & Consumer consultant
  - Music Therapist supportive
  - Contributed to other Safewards interventions
    - Discharge messages tree
    - Reassurance

Imagine Music Therapy and Safewards Mutual Help

Jannette Newell, Chris Darbyshire & Beata Karamchedut

AIM:
To assist consumers to reflect their experience of mental illness through reworded popular verse, and share their song with their fellow inpatients through the forum of our Safewards ‘Mutual Help Meetings’.

Why song writing?
- Creates opportunities for self-expression
- A sense of mastery and achievement
- Can provide a creative and engaging alternative to regular ‘talking’ therapies
- The process may also enable patients to experience relief, validation and joy.

Clinical song writing is a common intervention used by registered music therapists in acute mental health settings.

Working together!
Music Therapy + Safewards Model
Encourages collaboration amongst inpatients and contributes to a shared sense of community

Nurses could reduce disparities in access to choices of health care by welcoming therapeutic merges.

Outcomes
- Energetic, interactive & hopeful mood!
- Unprompted discussion and exploration of feelings between patients
- Recovery Journey has different meanings for individuals.

“This is very cool”
“I feel like I know everyone better now”

Description of the work
The amalgamation of music therapy into the Safewards Mutual Help Meeting was rewarding in that those who may not have ordinarily risked ‘trying something new’ were granted the benefits of music therapy.

So what does it mean for practice?
Consumers may share their reflections on their recovery journey: They wanted to share their insight, understanding and hope with fellow consumers.

Queensland Government
10. Discharge Messages

• On the day of their discharge, each consumer is to be asked if they would write a card for display on a special public notice board on the ward.

• Impact
  – Highly visible
  – Used as an initial intervention
  – NUM as champion
  – Outcomes from Mutual help meeting where low discharge rate
  – Messages from consumers and carers
  – Involvement from consumer consultants
Outcome
An important protective factor that can limit the likelihood of aggression is the strength of the therapeutic alliance between nursing staff and patients.

Analysis

- Measures (Chronbach’s α 0.8, 7-point Likert, Hx Nursing profession)
  - Ward milieu (Ward Atmosphere Scale)
  - Ward commitment (Organisational Commitment Questionnaire)
  - Therapeutic optimism (Elsom Therapeutic Optimism Scale)
  - Staff burnout (Maslach Burnout Inventory)
  - Focus groups (Senior/Junior - What worked; What didn’t)
Negative outcomes

• Mixed views
• Misunderstanding from staff
• “Safewards is about having to being nice to the patients” implying that without Safewards the recipricol would be the norm
• Rule based culture
Positive outcomes

• Morning meetings
• Difference to culture on ward
• Nursing took ownership
  – Spent more time interacting with patients
  – This is what good nursing care is about
  – E.g. outcome measurements mandated (10 years for 50% of patients rates according to the protocol)
  – Safewards way more complicated
Past, Present & Future

• Push change of culture
  – Difficult to change modus operandum
    • 30 years of practice/ rule based

• Talk to and talk about patients
  – Already doing this anyway
    • Reason for getting champions
    • Missed the point
  – Resistance from senior staff
    • really only for junior staff
  – Possibly 5-10 years to see real change
Next stage

• Structured risk assessment
  – cannot in itself change the outcome of aggression
  – must be accompanied with risk management strategies (Safewards)
  – mediates between the risk assessment and aggression

• Specialised units
  – SMHRU’s at Caboolture, TPCH & The Park

• Addition of Brøset Violence Checklist
Im Safe Brø
Score the patient at agreed time on every shift.

- Absence of behaviour - score 0.
- Presence of behaviour - score 1.

Total score can range from 0 – 6.
Maximum score (SUM) is 6.
In Summary

• BVC more reliable in predicting violence than clinical judgement

• Less than 1 minute to complete
  – rater must be familiar with the patient being rated

• Provides a standard method of assessing violence
  – controls for variation in clinical expertise

• Score has meaning for staff
Future Direction

• Will take time to embed culture change
• Engagement by management
• Engagement by all disciplines
• Training required
• Undergraduate learning (QUT)
• Possibly mandated