The Safewards Project
from research, model formulation, through trial to management action

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Conflict: potentially harmful events

- Aggression
- Rule breaking
- Substance/alcohol use
- Absconding/missing
- Medication refusal
- Self-harm/suicide

Containment: preventing harm

- PRN medication
- Coerced IM medication
- Special observation
- Seclusion
- Manual restraint
- Time out

Finding a way.........
Manual Restraint

• Within England:
  – Once every 10 days to every other day (136 wards)

• Between countries:
  – London 18%; Modena 10%; Athens 50% (838 patients)
Seclusion

- Within England:
  - 0-25% (31 hospitals, 522 patients)
  - Never to once every 5 days (136 wards)
- Between countries:
  - Norway 0%
  - Netherlands 25%
  - London 5%; Modena 0%; Athens 0.5% (838 patients)
Safewards model
simple form

- Staff modifiers
  - Patient modifiers
    - Originating domains
    - Flashpoints
    - Conflict
  - Containment
Six originating domains

1. STAFF TEAM: Internal structure, Rules, Routine, Efficiency, Clean/tidy, Ideology, Custom & practice
2. PHYSICAL ENVIRONMENT: Door locked, Quality, Complexity, Seclusion, PICU/ICA, comfort/sensory rooms, ligature points
3. OUTSIDE HOSPITAL: Visitors, Relatives & family tensions, Prospective –ve move, Dependency & Institutionalisation, Demands & home
4. PATIENT COMMUNITY: Patient-patient interaction, Contagion & discord
5. PATIENT CHARACTERISTICS: Symptoms & demography, Paranoia, PD traits, Depression, insight, Delusions & hallucinations, Irritability/disinhibition, young, male, abused, alcohol/drug use
6. REGULATORY FRAMEWORK: External structure, Legal framework, National policy, Complaints, Appeals, Prosecutions, Hospital policy
Safewards Trial

• Aim:
  – Devise a set of the most feasible interventions for inpatient nurses with potentially maximal impact on conflict and containment
  – Subject those to the most methodologically rigorous experimental test possible
  – Using the best (valid, reliable) outcome measures available
Development of interventions

Generated ideas
- July 2008 - Feb 2011
- 298 ideas based on model, our programme of research and lit review

Refined list of interventions
- Team ratings
- Selected top 30

Consulted expert nurses and service users
- Two groups of expert nurses and ward managers
- Rate feasibility
- SUGAR

Selected final interventions
- Feedback questionnaires
- Focus groups
- Dropped 5 of the most practically difficult and disliked interventions

Full Trial Jan-June 2013

Pilot study (2012)
- 15 interventions
- Four wards in East London
- Conflict declined on experimental wards, containment no change
The Safewards Trial
- final intervention list -

- **Experimental intervention** (organisational): clear mutual expectations, soft words, talk down, positive words, bad news mitigation, know each other, mutual help meeting, calm down methods, reassurance, discharge messages (n = 10) + handbook

- **Control intervention** (wellbeing): desk exercises, pedometer competitions, healthy snacks, diet assessment and feedback, health and exercise magazines, health promotion literature, linkages to local sports and exercise facilities
Going to the Mutual Help Meeting: The Fellowship of the Ward

THANKS NEWS SUGGESTIONS OFFERS
SAYING NO

Sympathise
Attend & Listen
Yes is best!
Identify with patient
Never forget a promise
Give good reasons

Not always right
Options
Our Mutual Expectations

1. We will always listen to one another.

2. Each patient will be orientated to the ward on arrival, and will receive a welcome pack to explain what to expect from their stay in hospital.

3. There will always be an opportunity for each patient to discuss their feelings and thoughts with staff one to one.

4. A minimum of one phone call per shift will be given to patients who may not have any other means of making outside calls. Staff can be flexible during times when a patient might need more support.

5. Neither the patients nor the staff will bring drugs or alcohol into the ward. For both patients and staff this will make disrespectful behaviour more likely, may have damaging effects on physical and mental health and may create dependency and addiction. Reluctantly, when this does happen it is the responsibility of the staff to ensure that it is stopped. People will be searched and the police will be involved when drugs are found.

6. Patients will be informed about their care plan.

7. Staff will respond to patient requests in a timely manner.

8. Whilst on the ward, patients will have access to various activities and a structured timetable.

9. Patients will be informed about the activities and therapies available to them, and how these can help with their recovery.

10. The nursing staff will provide patients with a form to document any side effects from medication, if requested.

11. The nursing staff will support patients to gain access to their personal files.

12. Patients will be informed in clear manner about medication, its side effects and the consequences of not taking it.

13. The nursing staff will refer all patients to necessary services, which will help in providing each patient with a better service and quality of care.

14. The nursing staff will ensure that all patients are treated with kindness, before attending any ward based groups or activities.

15. The nursing staff will show kindness, before attending any ward based groups or activities.
TALK DOWN TIPS

CONTROL YOURSELF
- Act calmly and confidently. Show no fear, orunter, or hurry. If not.
- Have measured, controlled arms and open hands.
- Breathe deeply and concentrate on situation.
- Relax body, no hands on hips or in pockets, don’t finger wag or prod.
- Don’t corner patients, threaten or make false promises.
- Don’t judge, criticise, show irritation, frustration, anger, or be retaliative. This is not
personal and it is not about you.
- Don’t argue or say they are wrong or you are right.
- Don’t deflect or justify yourself.
- Prepare responses in advance to typical insults.
- Let patient save face by having last word so long as they are complying.

DELIMIT
- Separate yourself from others if unsafe, people at risk.
- Move to a quiet place, ask to come aside.
- Invite patient to sit down.
- Establish and support backup.
- Maintain distance.

CLARIFY
- Ask what’s happening, use open questions.
- Sort out confusion.
- Use patient’s name.
- Orient patient to time, place, and person.
- Speak clearly, say who you are, remind of existing relationship, and offer your help.
- Wait a second and gain turn.
- Paraphrase and check what they have said.

RESOLVE
- Request politely, don’t command or be authoritarian.
- Give reasons, explain rules, reasoning behind them, be honest, express
fairness (or even agree that it’s unfair)
- Give patient opportunity to control him/herself.
- Make a personal appeal, remind them of previously agreed strategy.
- Deal with the complaint, apologise, make a change.
- Outline consequences of different courses of action.
- Offer choices and options, leaving power with patient.
- Be flexible, negotiate, avoid power struggle, compromise
- Ask if there is anything else you can do or say that will gain their coopera-
ition, ending positively.

RESPECT & EMPATHY
- Show interest, concern and expression congruent with words.
- Have a concerned and interested tone of voice.
- Listen, hear, acknowledge feelings and needs, be sympathetic.
- Take time to hear the patient out, be patient and don’t hurry them.
- Don’t yell over them or shout - wait until they take a breath.
- Make eye contact (exercising care not to be confrontational).
- Extend self and thinking to understand patient viewpoint.
- Show sincerity, authenticity, and genuineness.
- Don’t tell the patient what they should or should not do.
- Don’t discount, trivialise or undermine their opinion or suggestion.
- Don’t advice giving and no orders, no “It’ll...
- Don’t mock patients or treat them as a child.
- Don’t overly smile or this may be seen as condescending.
- Answer all requests for information, however they are phrased.
- Empathise with feelings, not aggressive behavior ("I understand you are angry but it is not ok to hit so and so...")
Be flexible. Talk about any task you want a patient to do. Explore the patient's point of view, so that they can feel heard and valued, and so that the timing or precise content of the task can be adjusted to suit their wishes. Understand the blocking factors and find workarounds and compromises.
The Safewards Trial
- the sample -

- Included: Generic acute wards, PICUs, Triage, Assessment, Treatment.
- Excluded: forensic, elderly, CAMHS or other speciality
- Excluded: wards with two or more of the following conditions – acting ward manager, locum consultant psychiatrist, nursing vacancy rate > 30%
- 2 randomly chosen wards at each of 15 randomly chosen hospitals in SE England (42 eligible hospitals in consenting Trusts within 100 km central London)
- One Trust declined to participate, 7 hospitals excluded following selection due to planned reconfigurations/ward closures
- At each hospital, wards randomly allocated to experimental or control conditions
- All randomisation and analysis independent
The Safewards Trial - design -

- Single blind Cluster Randomised Controlled Trial
- 8 weeks baseline data collection, 8 weeks implementation, 8 weeks outcome data collection
- Wards and researchers only informed of allocation 2 weeks before implementation started
- Wards and their staff blind as to which was the experimental and which the control intervention until after the study
- Primary outcomes: conflict and containment via PCC
- Secondary outcomes: WAS, APDQ, SHAS, SF-36, LoS, economic
- Fidelity: researcher checklist and end of study questionnaire
- Process and reaction to change: observational reports from researchers
The Safewards team
The Safewards Trial
response rates and completion

- Preparation: manager contacts and hospital visits started 8 months before trial
- One hospital with 3 wards, = 31 wards
- 31 wards made it all the way through (no drop outs)
  - Events and changes (+delayed changes, SLaM, CNWL)
  - Reactance, difference/individuality
- 564 staff gave signed consent (88%)
- 8,368 PCCs returned (53.6% of total possible)
- 2,704 additional questionnaires completed (62% baseline, 44% outcome)
- All questionnaires scanned and then double checked
Fidelity to the interventions (by ward)

- Researcher checklist (outcome period):
  - Experimental m 38%, sd 8, range 27-54%, n=271
  - Control m 90%, sd 9, range 69-99%, n=209

- End of study questionnaire:
  - Experimental m 89%, sd 11, range 62-100%, n=79
  - Control m 73%, sd 19, range 39-100%, n=74
Main outcomes

**CONFLICT**
- 14.6% decrease
- CI 5.4 – 23.5%
- \( p = 0.004 \)

**CONTAINTANMENT**
- 23.6% decrease
- CI 5.8 – 35.2%
- \( p = 0.0099 \)
Sensitivity analysis

- Dropping wards with serious changes
  - Change from acute to assessment, results still significant
  - Fire and several ward moves, results still significant
- Dropping wards with <20%, <30% and <40% data return rate in outcome phase, all results still significant
- Dropping outlier ward with high rate of conflict at baseline (m15 vs 5) results still significant
- Testing missing data bias – not yet complete
Limitations

• Strengths:
  – Randomisation, blindness, control
    intervention, adequate power, independence
    of randomisation and analysis

• Weaknesses:
  – Poor level of cooperation and implementation
    from ward staff, null result for questionnaires
Summary

- A brand new, large scope explanatory model has been formulated: the Safewards Model
- Its test, the Safewards RCT, has had a positive outcome on both conflict and containment
- We recommend that inpatient nurses implement these interventions
- Complementary to Starwards, which we also recommend
- Compatible with, and enhances AIMS accreditation
- A full Safewards Model description is available (JPMHN)
- We will mount a large scale dissemination exercise ([https://www.facebook.com/groups/safewards/](https://www.facebook.com/groups/safewards/); youtube safewards channel; www.twitter.com/safewards; email list contact Geoff.Brennan@kcl.ac.uk; dedicated website underway
- We will be seeking collaborations everywhere, as the application of this model is in everyone’s hands
- Research continues, any model is always only an interim step to some better place

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Ethics

• NRES Committee London-Dulwich 11/LO/0798
• Preparation and comprehensive justification including precedents relating to cluster RCTs
• Trust CEO gave signed consent on behalf of all patients
• Participating staff gave signed consent in their own behalf
• Signs on wards about participation in the study
• Leaflets providing information to staff and patients
Wards compared at outset

- No difference: gender, type, bed numbers, environment quality, security scores, staff age, staff ethnicity, staff marital status, or staff declared exposure to violence
- Experimental wards had higher staffing levels, especially qualified nurses, and more staff who had older dependent children, and more staff who had been in post longer than a year
- Experimental wards had significantly lower order and organisation, and one or two indications of higher staff stress, in comparison to control wards
- Other questionnaires (APDQ, SHAS, SF-36) no difference
Contamination

• Secrecy commitment, but managers knew and staff were shared b/w wards
• Three quarters admitted to discussing and knowing what was going on on the other ward
• The majority in both groups thought they were in the experimental group, but that proportion was higher in the experimental group (88% vs. 74%)
• But getting ward nurses to do anything was difficult – copying unlikely
• Any contamination would attenuate the experimental effect – thus enhances rather than undermines findings
Nursing response (observational study)

- Adoption
  - Enhancement; Enthusiastic take-up; Adaptation (positive); Dilution; Adaptation (negative)

- Ambivalence

- Resistance
  - Mild subversion; Dismissiveness; Refusal to participate; Sabotage

- Abandonment
  - Contextual; Other
Questionnaires

- WAS: no differences, either group, on oo, sc, pc
- APDQ: both groups improved over time on three subscores - security, acceptance, enthusiasm (following or leading?)
- SHAS – both groups improved over time on one subscore – needs function
- SF-36 The only item showing change was about walking distance and changed on the control wards
- Absolute final results not yet computed