Keywords Safety/Risk assessment/ Training

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In this article...

- The recent issues and developments relating to safety in acute mental healthcare
- The behaviours and strategies identified by the Safewards model as causing issues
- Case studies using the alternative strategies suggested by the model

A model to improve safety on acute inpatient mental health wards

Key points

Safety in health settings involves patients' and staff members' physical and emotional wellbeing

All acute wards experience risk, but the nature of serious mental health problems causes additional, specific risks such as anger caused by detention

A model called Safewards has identified conflict behaviours that commonly present in mental health service users and containment strategies often used by nurses

Safewards suggests 10 alternative interventions; case studies show that it benefits patients and staff in mental health and other settings

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Abstract Several factors have contributed to the current level of challenge in maintaining a safe environment for patients and staff on acute mental health wards. This article looks at these, including the increased role of a risk-management culture, which promotes restrictive practices that provide short-term solutions to violence and aggression but may lead to an overall reduction in physical and emotional safety. It also discusses the theory, application and potential use in other settings of Safewards, a model that uses interventions to improve interactions and the ward environment.

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Many risks faced by patients in acute mental health settings are similar to those that occur in other areas of healthcare, for example medication errors and cross-infection. In addition, however, there are unsafe behaviours associated with serious mental health problems, including violence and self-harm; the measures taken to address these, such as restraint or seclusion, may result in further risks to patient safety (Thibaut et al, 2019). This article discusses the need for a physical and psychosocial environment in which staff, patients and visitors feel recognised and valued.

Background

Over the last 10 years, a challenging mix of pressures has affected the NHS; while some are common across all sectors, others are specific to mental health and have had a severe impact on how safety for patients and staff can be maintained on acute mental health wards.

One such pressure is a reduction in inpatient beds: since 1987-88 the number of mental health beds in England has fallen by 73%, while occupancy has increased to an average rate of 90% (The Strategy Unit, 2019). The reduction in bed availability has resulted in stricter criteria for hospital admission, meaning most inpatients are acutely unwell. It has also meant that the number of patients detained under the Mental Health Act 1983 has increased, rising by 40% between 2005-06 and 2015-16 (Care Quality Commission, 2018a). The lack of bed availability has also caused increased patient turnover, although this has been offset by delayed transfers of care due mainly to accommodation issues (Gilburt, 2019).

Another source of pressure on the NHS has been staffing shortages, particularly in nursing. The Care Quality Commission (2018b) noted a 12% fall in the number of mental health nurses between 2010 and 2017, and The King's Fund highlighted an increased reliance on bank and agency staff, meaning the level of experience of trained nurses on acute wards has fallen due to the high staff turnover rate (Gilburt, 2019).

Galante et al (2019) found there was also a sharp rise in out-of-area placements: these rose by 40% between 2014 and 2016 and, while this has now levelled, there has been

Box 1. Conflict: potentially harmful events

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

Source: Bowers (2014)

no significant reduction. They showed these placements are not usually driven by clinical need, yet they are expensive, inefficient, distressing for patients and may increase risk, for example of self-harm.

In addition, there has been a steady increase in the number of incidents involving illicit drugs on acute mental health wards. As early as 2002, there was considerable concern among ward nurses about the supply and use of both illegal drugs and unauthorised prescription medication, as well as the potential this caused for disturbed and violent behaviour (Bowers et al, 2002). In late 2019, *The Independent* published an article online highlighting the increase in illicit drug use in all NHS inpatient settings, singling out mental health wards as particular hotspots (Lintern, 2019).

Unsurprisingly, all the factors listed above have a significant impact on nurses' safety, wellbeing and morale. Between 2013 and 2014 there were 68,683 physical assaults on NHS staff and almost 70% of these happened in the mental health sector. Renwick et al (2016) examined incidents in which nursing staff had been injured in English mental health trusts, as reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, and found that 27% had happened while staff were restraining patients.

In contrast to these pressures, there have been recent positive developments, such as increased attention to physical safety on wards – for example, through the removal of potential ligature points and the provision of single-sex wards and individual patient bedrooms. There has also been a much stronger emphasis on the importance of infection prevention and control, as required by the Health and Social Care Act 2008 and reinforced by the CQC's (2013) inspection standards.

Evidence on the health inequalities experienced by people with serious mental health problems has increased, including, for example, the finding that the life expectancy of people with schizophrenia or bipolar disorder is 15-20 years shorter than that of the general population (Green et al, 2018). As a result of this increased knowledge, mental health nurses are more aware of physical health conditions and the need to carry out baseline and routine physical observations and to refer patients for specialist investigations or treatment when required (Green et al, 2018).

Safety and risk management

Slemon et al (2017) suggested that, although the concept of safety across healthcare settings draws on a cluster of ideas (including patient safety, quality assurance and quality improvement) mental healthcare has diverged from this consensus. It has led, they argued, to the current situation, in which recognition of the potential harm caused *by* the healthcare setting is often overshadowed by concern about the harm a patient may cause *in* that setting. This trend has resulted in a risk management culture in mental healthcare, in which restrictive practices are often seen as the first response; in fact, this creates additional risks, including feelings of distress and dehumanisation for patients and of cognitive dissonance for nurses.

Use of restraint and seclusion

The Department of Health's (2014) *Positive and Proactive Care: Reducing the Need for Restrictive Interventions* aimed to reduce all forms of restriction, but focused specifically on face-down (prone) restraint, which had been shown to be dangerous and, on occasion, fatal. That guidance was followed up with Mind's (2015) *Restraint in Mental Health Services: What the Guidance Says*, which identified 9,600 uses of restraint in mental health trusts and independent provider services over one month (August 2015), along with 1,671 incidents of seclusion. Mind's report featured service users' perspectives on the distress caused by these practices, highlighting potential issues around ethnicity, gender, racial and cultural stereotypes, and misunderstandings that persist in practice. Women *and* men can be retraumatised by restraint that parallels past physical or sexual abuse, which can be heightened depending on the gender of the staff member doing the restraining.

Despite the publication of these documents, three years later *The Observer* reported that 3,652 mental health patients had been injured due to restraint in 2016-17 (Campbell, 2018) and Mental Health Today (2018) identified that the deaths of 32 women and girls were linked to restraint between 2012-13 and 2016-17.

Movements for change

The recovery movement is an international coalition of mental health patients (who often self-define as service users or survivors), carers and supporting professionals. It began in the 1980s and has grown since then. Members share experiences and campaign about a range of issues, including improved access to mental health services and a reduction in medicalisation and forced treatment. An ongoing theme relates to the use of restraint and seclusion, with an emphasis on the retraumatising effects of these practices (Slade et al, 2014). Other campaigning groups have also formed, such as the Restraint Reduction Network (restraintreductionnetwork.org), which provides training and develops standards.

By consistently highlighting their concerns, the work of these campaigning groups has led to some improvements in UK mental health services, such as the:

- Reintroduction of single-sex wards;
- Development of safety guidelines and staff training in the use of restraint and seclusion.

However, the CQC (2018b) cautions that it is impractical to simply introduce single-sex wards universally; to prevent sexual assault and harassment, other measures (such as staff training) are required in settings like out-of-area placements.

The Safewards model

Safewards, introduced by Bowers (2014), is an evidence-based model formulated specifically for use on inpatient mental health wards. It was developed on the basis of research that showed a huge variation (up to tenfold) in incidents of violence, restraint and seclusion between different acute mental health wards with similar patient populations. The two key concepts underpinning the model are:

- Conflict – the behavioural risks that present in acute mental healthcare (Box 1);
- Containment – the range of well-established responses on which nurses

Box 2. Containment: strategies to prevent harm

- As-required medication
- Coerced intramuscular medication
- Special observation
- Seclusion
- Manual restraint
- Time out

Source: Bowers (2014)

draw either to manage and de-escalate, or to prevent, these incidents (Box 2).

Bowers' (2014) research showed a strong association between conflict behaviours. As an example, wards on which there were many aggressive incidents also saw high levels of self-harm and absconding. There were similar patterns in containment strategies – where seclusion was often used, so were other forms of containment. The containment strategies identified each carry risks to patients – for example, manual restraint can cause severe physical and psychological harm, while rapid tranquillisation (a form of coerced intramuscular medication) can result in serious respiratory depression (National Institute for Health and Care Excellence, 2017).

Bowers (2014) identified six originating domains that could cause flash points (Table 1) – situations that could lead to conflict behaviours and potentially trigger one or more of the ward's containment strategies. He saw the staff team domain as the most influential because he believed nursing staff have the greatest control over the physical and psychosocial quality of the ward environment, how ward routines and policies are implemented, and the beliefs and values that inform how the team talked to, and about, patients.

In Bowers' (2014) research, alternative ways nurses could respond to potential/actual disruptive behaviour without immediately using the containment strategies were identified; these were tested and refined through a randomised controlled trial on 31 wards at 15 different hospitals (15 wards trialled Safewards and 16 used a different programme). The results showed that wards using Safewards reduced conflict by 15% and containment by 24%, compared with controls. As a result, a set of 10 interventions (Table 2) was formulated as the best way to create a positive ward environment that maximises patient–staff collaboration and communication, along with tools to prevent, contain and de-escalate actual/potential flash points.

Table 1. **Six domains influencing conflict and containment**

Domain	Key features
Staff team	● Internal ward structures ● Rules ● Daily and weekly routines ● Customs and practice in dealing with disruptive behaviour
Physical environment	● Quality ● Cleanliness and attention to repairs ● Patients' choice over decoration and furnishings
Outside the hospital	● Family and relationship demands ● Bad news ● Accommodation and financial issues
Patient community	● Contagion (eg, self-harm spreading in a patient group) ● Conflict over shared space and behaviour
Patient characteristics	● Symptoms ● Personality traits ● Demographic features
Regulatory framework	● Access to information about legal rights and appeals ● Support to exercise rights

Source: Bowers (2014)

Rolling out Safewards

Since the trial, Safewards has been adopted in hospitals across the UK and the world; below are good-practice case studies.

Norbury House Psychiatric Intensive Care Unit, Stafford, UK

This 13-bed mixed unit provides care for patients who are difficult to manage on a standard acute mental health ward and, as a result, is very likely to experience a high volume of conflict and containment incidents. The unit introduced Safewards in 2014 and over the following six months saw a 23% decrease in the use of physical interventions, including a 42% reduction in prone restraint (DH, 2015). The team also reported many incidents in which using Safewards interventions resulted in qualitative benefits, including the following examples:

- In the nursing handover following a difficult shift, a staff member shared the strengths and positives of a very challenging patient; this had a positive impact on the care and attitude of the staff on the next shift;
- A know-each-other folder was created, so staff and patients could share general personal information about interests and hobbies; this broke down barriers and meant conversations could extend beyond symptoms and illness;
- Talk-down methods were used to engage with a patient who was highly distressed and feeling close to harming himself; previously, he had not engaged well with staff when experiencing these feelings but the staff member used a calm, non-confrontational manner to offer support, understanding and alternatives.

Charlesworth Ward, Lincolnshire Partnership NHS Foundation Trust, UK

This is a 20-bed acute ward for women aged 18-65 years; the average length of stay is 27 days. Safewards was implemented in phases to embed staff learning and allow the monitoring of the impact of individual interventions; to help with this, the team appointed a staff champion for each intervention. Many improvements were noted including a reduction in staff absence rates over the pilot period (DH, 2015).

Acute mental health wards, Victoria, Australia

Safewards has been rolled out on a large scale across Victoria in Australia. It was launched in 2016 as part of a four-year plan that began with implementation on all mental health inpatient wards statewide, including a 12-week trial period.

Implementation was supported by forming the Safewards community of practice; this was a group of staff who met four times a year and produced a series of short videos to illustrate each of the 10 interventions. An evaluation by the Centre for Psychiatric Nursing at the University of Melbourne showed consistent use of the model in the first year, improvement in patient and staff safety, and a 36% reduction in seclusion use (Fletcher et al, 2017).

Berkshire Healthcare NHS Foundation Trust, UK

This trust started to implement the Safewards model in all inpatient areas in 2014, including on its wards for older adults with functional mental health problems and dementia. To suit the patient group, nursing staff decided to adapt the Safewards model to take into account the impact of patients' cognitive impairment

Table 2. **The 10 Safewards interventions**

Intervention	Example
Clear, mutual expectations	● On admission, patients are told the ward ground rules and what staff agree to do in return
Soft words	● Short advisory statements that use empathy and listening and acknowledge feelings
Reassurance	● Speaking to patients individually after a difficult incident and explaining what happened (adhering to confidentiality) ● Giving hope and setting goals for the future
Mutual-help meetings	● Regular meetings for all staff and patients to share information and check how people are
Bad news mitigation	● Proactively responding to bad news ● Sensitivity and timing in sharing bad news, being mindful of its impact on the patient ● Offering practical support
Positive words	● A strengths-based approach in which something positive is shared about each patient at all nursing handovers, recognising progress and constructive behaviour
Calm-down methods	● Giving patients alternative choices (eg, a walk, music or a relaxation session) before offering medication ● A calm-down box with items to borrow
Discharge messages	● A display board with positive messages from former patients
Talk-down methods	● Defusing conflict using calm words and non-threatening body language
Know-each-other methods	● Sharing structured information about patients' and staff members' favourite food, music or sport through, for example, a photo board or folder (without breaching boundaries)

Source: Bowers (2014)

and the higher level of involvement of relatives and carers. Instead of holding weekly mutual-help meetings, a more individual approach was used, and carers were consulted to promote their support and active participation. Patients' involvement was also encouraged; for example, the older adults wards' art group designed and produced a tree displaying discharge messages from former patients. Incidents requiring the bad news mitigation intervention were discussed in staff handovers and agreed actions included in care plans (DH, 2015).

Future developments

In the UK, the charity St Christopher's Fellowship is adapting the model to use in its children's service; it will be renamed Safehomes. The adaptation is needed because, although its service users display similar conflict behaviours to those identified in the Safewards model, the nature of containment strategies used is different.

In Australia, the state of Victoria has rolled out an adapted version of Safewards on a medical ward and is piloting it in emergency departments in two services; evaluation results are expected at the end of 2020. An adapted model, SafeCentres, has also been implemented at Ashley Youth Detention Centre in Tasmania, a 50-bed mixed unit for 10-18-years-olds. All staff (including catering and administrative staff) have received training, and residents have been involved through newsletters and a competition to design a logo.

Bowers (2014) cautions that, while Safewards may well have useful lessons for other settings – particularly prisons and young offender services – the model is firmly grounded in research on acute mental health wards. As yet, there is no available evidence about other applications, so interventions may not be transferable.

Conclusion

While the Safewards model does not have all the answers to the systemic and structural challenges of acute mental healthcare, it provides a tested, holistic framework to improve communication between patients and staff, and the overall ward environment. The successful introduction of a modified form of Safewards on older adult wards suggests the original model's principles are also relevant outside of acute mental health wards; recent applications in medical wards, emergency departments, children's services and offender units are awaiting evaluation. Whatever the outcome, it appears the 10 interventions have struck a chord far outside their immediate context and are, therefore likely to be of interest, and use, to nurses in a range of healthcare settings. **NT**

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