A model to improve safety on acute inpatient mental health wards

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).

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...
Clinical Practice

Discussion

Box 1. Conflict: potentially harmful events

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

Source: Bowers (2014)

 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:

- 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)
Discussion

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 ward staff 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

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

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.
Clinical Practice

Discussion

Table 2. The 10 Safewards Interventions

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

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 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

References


Campbell D (2018) Figures Reveal ‘Alarming’ Rise in Injuries at Mental Health Units. theguardian.com (The Observer), 10 June.

Care Quality Commission (2018a) Mental Health Act: The rise in the use of the MHA to detain people in England. CQC.

Care Quality Commission (2018b) The State of Care in Mental Health Services 2014 to 2017 CQC.

Care Quality Commission (2015) A Fresh Start for the Regulation and Inspection of Mental Health Services: Working Together to Change How we Regulate, Inspect and Monitor Specialist Mental Health Services. CQC.

Department of Health (2015) Positive and Safe Champions’ Network. DH.

Department of Health (2014) Positive and Proactive Care: Reducing the Need for Restrictive Interventions. DH.


Gilburt H (2019) Securing Money to Improve Mental Health Care... But No Staff to Spend It On. kingsfund.org, 22 October.


Lintern S (2019) NHS Hospitals Fighting Hidden Drugs: War as Patients Order Class A Narcotics for Delivery to their Beds ‘Like Pizza’. independent.co.uk, 10 November.

Mental Health Today (2018) 32 Women Die Following Restraint. mentalhealthtoday.co.uk, 3 July.


National Institute for Health and Care Excellence (2017) Violent and Aggressive Behaviours in People with Mental Health Problems. NICE.


The Strategy Unit (2019) Exploring Mental Health Inpatient Capacity. TSU.