ACT Government

The *Safewards* Model of Care Trial in the ACT

Post-Implementation Review

November 2021

Policy Design and Evaluation Team

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We wish to acknowledge the Traditional Custodians of the ACT, the Ngunnawal People. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Executive Summary

The Safewards Model of Care ('Safewards') is an adaptable program of evidence-based nursing interventions that were tested over the course of a 20-year research program led by the Institute of Psychiatry at Kings College London.

While these interventions were originally developed for use in the mental health setting, they have much broader applicability. In many ways, they simply strengthen existing principles of good nursing practice such as those espoused by the Royal College of Nursing:

- Treating everyone in one's care with dignity and humanity,
- Promoting care that puts people at the centre by involving patients, service users, their families and their carers, and
- Taking responsibility for the care we provide.[1]

As the UK research and subsequent implementation in Victoria and NSW demonstrated, Safewards is effective in reducing conflict and containment.[2,3] It also gives agency to nurses and other clinical and supporting staff.

As a consequence, Safewards is a strong fit with strategies that aim to limit the occurrence and impacts of occupational violence (OV), as well as broader culture change strategies that seek to embed respect, inclusion, and collaboration across organisations.

This post-implementation review reports on the Safewards Model of Care (MoC) Trial in the ACT, carried out in 2021 across four wards in the ACT health system – two wards at Canberra Health Services (CHS) and two at Calvary Hospital.

Notably, the trial included two medical wards, representing one of the first times that Safewards has been rolled out *systematically* in a medical ward.

The review sought to answer questions relating to training, acceptability, implementation, and outcomes. Key evaluation questions were informed by the Victorian Safewards trial evaluation project,[4] and methods included document analysis, focus groups, survey data, and stakeholder interviews.

Key findings

In summary, the review team concluded that Safewards was implemented successfully in the ACT and that it holds great promise, but also that it needs to be rolled out with care, as implementation success varied across the four wards in the ACT trial.

Interestingly, the review found that implementation in the ACT was very successful in the medical wards, which is a highly encouraging sign and bodes well for a wider rollout of Safewards across the ACT health system.

Factors determining the degree of success in implementing Safewards in wards included readiness for Safewards, leadership at various levels, staff 'buy-in', and ongoing support and training. Practical experience with Safewards appears to be an important learning tool.

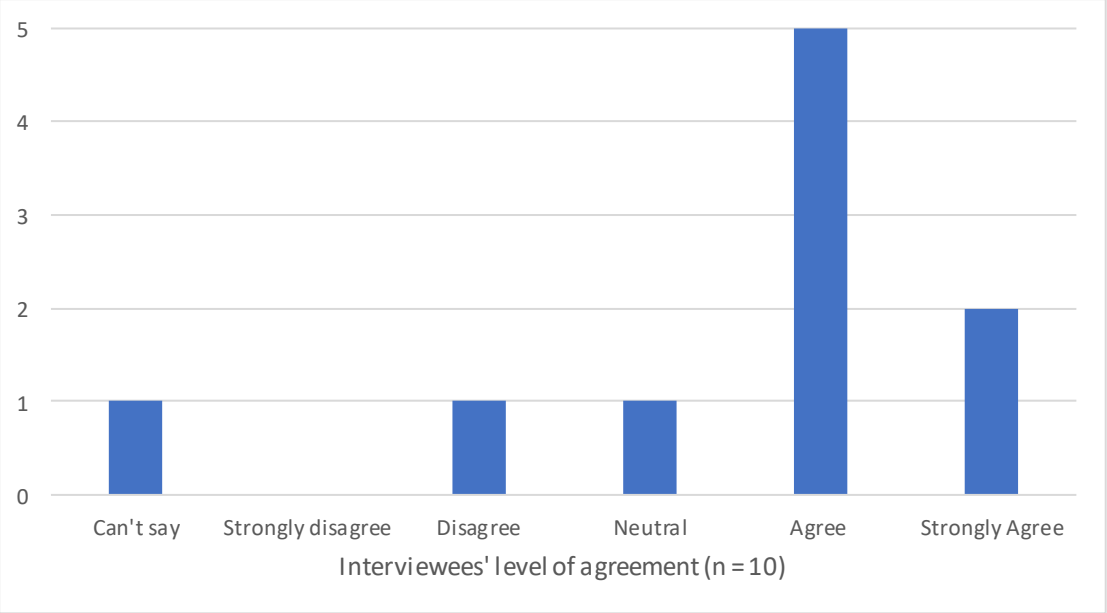
Our survey of nurses and midwives (n = 293) in the ACT health system, which was completed in July 2021, found that:

- The majority of Safewards nurses thought that the model of care had had an impact on conflict and containment in their workplace (56 per cent),
- Two out of three Safewards nurses thought their colleagues viewed Safewards favourably (64 per cent),
- Only 23 per cent of Safewards nurses thought their workplace was *unsafe* (compared to 37 per cent of nurses not working on Safewards wards), and
- Nearly half of all Safewards nurses had heard positive consumer/patient responses.

Data from training workshops, participant focus groups, and stakeholder interviews corroborate the view that Safewards and its implementation has been perceived in a positive way by most nursing staff, patients, their carers, and allied health staff.

Anecdotally, observations made about seclusion events at one of the mental health wards suggest that there has been a dramatic reduction in such events; interviewees however also noted that other initiatives that were being implemented contemporaneously may also have played an important role in reducing the number of seclusion events.

Figure ES1 Was the Safewards trial implemented successfully in the ACT?



Overall, as Figure ES1 above reveals, most stakeholders interviewed for this review agreed or strongly agreed that the trial was implemented successfully in the ACT. Only one out of ten disagreed.

Figure ES2 below, which is based on project documents and transcripts of interviews, gives an indication of where the focus of the implementation was, and supports the view that appropriate emphasis was placed on key topics such as staff, time, safety, and people.

The review identified leadership motivation and involvement as critical enablers for the successful implementation of Safewards; early staff engagement also led to more efficient implementation processes resulting in better collaborative efforts overall.

Leadership at all levels is an enabler and includes successful role modelling at the middle manager level (e.g., Clinical Nurse Consultants, Clinical Development Nurses, and Clinical Nurse Educators).

If wards are not sufficiently prepared or supported, Safewards can become a burden on a ward rather than a driver for good nursing practice. In addition, the review found that some interventions appear to be more difficult to implement than others.

> Wards which are not quite ready to roll out Safewards may benefit from a stepped implementation process starting with building knowledge about the model (initial understanding), prior to rolling out of perhaps just one or two of the 'easier' interventions.

The implementation was well managed by recruiting experienced Safewards trainers from other jurisdictions, establishing a well-managed project office supporting the wards, collecting relevant information and procuring academic advice from experts at the University of Melbourne Psychiatric Centre for Nursing, and monitoring implementation activities meticulously.

Figure ES2: Stakeholder interviews word frequency analysis

Challenges, barriers and limitations

Barriers and challenges included time pressures and resource needs which limited the ability of some wards to fully embrace and implement the model. COVID-19 added to these pressures, explaining why some wards requested more support.

Staff enthusiasm in general was a critical enabler but was also noted as a potential barrier – it appears that implementation success was at least partially due to the enthusiasm for Safewards.

It cannot be assumed that such enthusiasm will always be present when considering a wider rollout; in other words, strategies need to be developed that mean the success of Safewards is not overly dependent on particularly enthusiastic individuals.

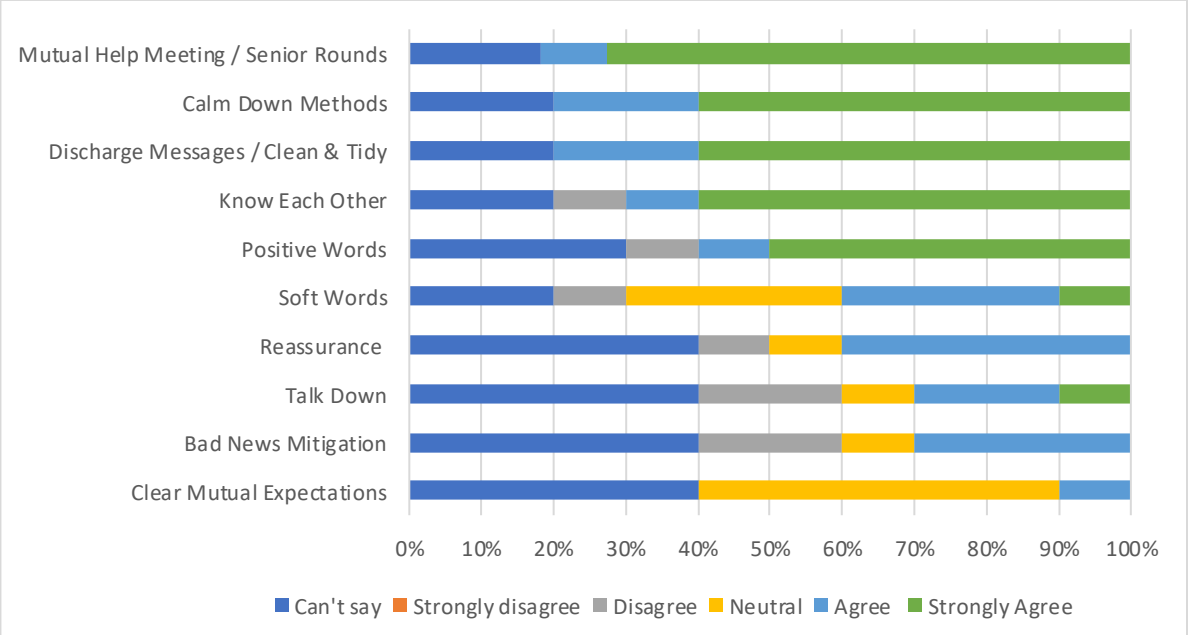
Some of the original Safewards interventions were also modified to suit respective ward environments in the ACT, notably on the medical wards. This may limit the comparability of the results reported here.

> While not all interventions were implemented to full fidelity, the review team concluded that changes made to the interventions were in line with the underlying model.

RiskMan data on incidents was not fine grained enough, and numbers generally too low, to permit inferences to be made on how many occasions of violence occurred on participating as opposed to non-participating wards.

Finally, as identified previously, some interventions were easier to implement than others. As Figure ES3 demonstrates, there was very good agreement with the 'Top 5' interventions as being successfully implemented, while there was less agreement on the 'Bottom 5'.

Figure ES3 Success of implementation by intervention type, interviewees' opinions (n = 10)



Some of the challenges that were reported included time and 'buy-in' from clinical staff, for example, with the Bad News Mitigation intervention, while others were seen as more difficult to put into practice and involved additional work for which there was limited time and support available (e.g., Clear Mutual Expectations).

Recommendations

To further enhance successful implementation, especially in light of further extension of the Safewards model to other wards, dedicated support resources, more structured implementation monitoring data, staff training and rotation opportunities and clear pathways to Safewards would be beneficial.

Considering all sources of evidence, the following recommendations are made:

Recommendation 1: Expand the Safewards implementation to additional wards

The review finds that there is very little 'downside' to rolling the program out to additional wards, but significant benefits which are also in line with wider strategies on OV and culture change across the ACT's health system.

Recommendation 2: Provide continuous training and support for new staff and non-participating nurses

New staff members and non-participating nurses need to have a strong understanding of the model and associated interventions. Consider additional trainer resources for wards facing issues implementing the interventions.

Recommendation 3: Provide training, placement and/or staff rotation opportunities to improve awareness and knowledge

Opportunities to work on wards that have successfully implemented Safewards would lift knowledge and awareness across wards, which would also support professional competencies and a more standardised approach to the management of patients.

Recommendation 4: Engage "Executive Safewards Ambassadors" to increase leadership visibility and provide critical support to their middle managers

"Safewards Champions" were identified at the beginning of the trial phase, but ongoing engagement of executive leaders is crucial to promote awareness, uptake, and acceptance.

Recommendation 5: Collect structured data in relation to staff and healthcare consumers' attitudes

A structured data collection plan including administrative and survey data would strengthen evidence and allow for impact evaluations in the future.

Recommendation 6: Identify "Pathways to Safewards"

It is important to ensure that wards which for a variety of reasons may struggle with a full rollout of Safewards are not left behind. These wards may indeed be *precisely* the wards which could benefit most from implementing the model of care. A stepped program could be considered.

Introduction

The ACT Health Directorate's work on the Safewards trial began in 2020 with the aim of implementing the Safewards model along the lines as had been successfully achieved in the Victorian public mental healthcare setting.

Like the Victorian Safewards Trial, the ACT Health Safewards trial was not devised as an experimental research project; there was no control intervention or randomisation of sites as was the case in the UK randomised controlled trial.

The ACT Safewards trial, with initial training in 2020, was implemented in 2021 in four wards across Calvary Public Hospital and Canberra Hospital, which included two medical wards and two adult mental health units.

The wards were selected based on a request sent to the General Manager of Calvary Public Hospital Bruce and the Chief Executive Officer of Canberra Health Services (CHS). Table 1 lists the trial sites.

Table 1: Safewards Trial wards

Ward name	Ward type	Organisation
4 West	Medical	Calvary Public Hospital
7 B	Medical	Canberra Hospital
Adult Mental Health Unit (AMHU)	Mental Health	Canberra Hospital
Older Persons Mental Health Inpatient Unit (OPMHIU)	Mental Health	Calvary Public Hospital

Trainers that had participated in the Victorian Safewards implementation assisted with training (further discussed in the section on pre-implementation training below).

Literature overview

Workplace safety in clinical settings has many components. Around the world, the reduction of Occupational Violence (OV) is a major focus of governments and health authorities. Health services report assaults and violence against nurses and midwives on a daily basis.

OV places clinical staff at risk of major harm,[5] causing physical and mental trauma. Furthermore, conflict and violence disrupts therapeutic relationships.[6]

Conflict is especially prevalent in mental health settings, in which conflict behaviours frequently led to restrictive or coercive practices.[6] Restrictive practices include restraint, seclusion and/or enhanced observation and are administered by clinical staff to reduce safety risks.[3]

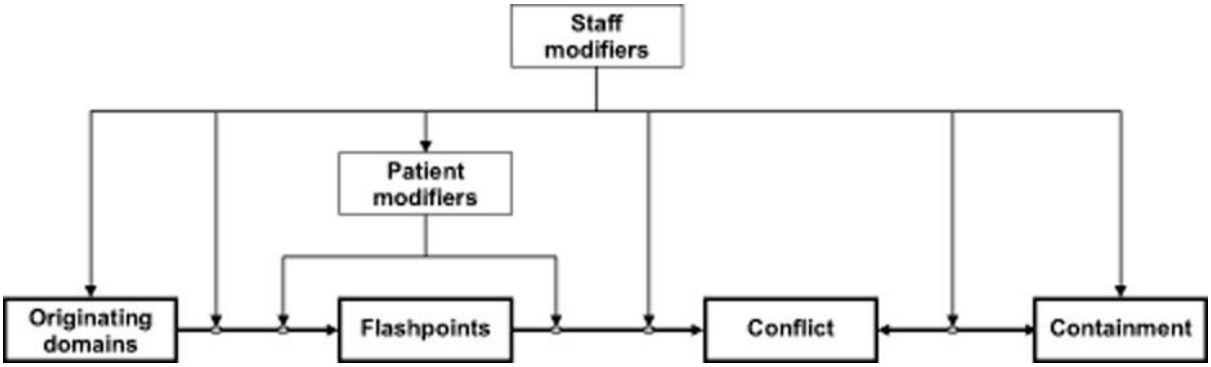
Current best practice suggests that restrictive practices should be considered as a last resort given the damage they can inflict on staff and patient relationships,[3] and noting also that they may be associated with an increased rate of self-harm and injury.

"Safewards" is one of the models that has been developed to reduce containment and conflict on wards, specifically in acute mental health settings.[2]

Safewards as a Model of Care includes the model itself and associated interventions. Safewards was originally developed in acute mental health settings and explores the link between conflict and containment practices.

Furthermore, the model aims to provide agency to nurses and other clinical staff by providing opportunities to reduce conflict and to apply fewer restrictive practices.

Figure 1: The Safewards model



Source: Bowers (2015).[3]

The original Safewards model was tested in 2013 in a Randomised Control Trial (RCT) in 31 acute mental health wards in the UK.[3] To analyse outcomes, conflict was measured with a ward-based survey and containment was measured using seclusion events.

The experimental trial in England showed that Safewards was associated with both reduced conflict and reduced use of seclusion. In short, Safewards includes ten main interventions that were identified in the UK through Randomised Control Trials (RCT),[2,3] following the model shown in Figure 1 above.

In this model, "*originating domains*" describe the ward settings, *"staff modifiers"* designates the features of staff/client interactions that can influence conflict; *"patient modifiers"* relate to client behaviours which can be influenced by staff, *"flashpoints"* are signals relating to imminent conflict behaviours, and "conflict" relates to patient behaviours that threaten their own and staff safety.

The main 10 Safewards interventions are:

> Clear Mutual Expectations

- Soft Words
- Talk Down
- Positive Words
- Bad News Mitigation
- Know Each Other
- Mutual Help Meeting (Mental Health ward) / Senior Nursing Round (Medical ward)
- Calm Down Methods
- Reassurance
- Discharge Messages (Mental Health ward) / Clean and Tidy (Medical ward)

These interventions were easy to implement with a relatively high impact from the outset. The RCT did demonstrate a reduction in restrictive practices on 31 psychiatric wards in the UK following implementation.[3] The model has subsequently been implemented internationally.[7-10]

Review scope and plan

The review focuses on lessons and learnings from the implementation of the Safewards trial in the ACT, noting the context of COVID-19 and changes made in response to the pandemic situation.

Key Evaluation Questions

Questions in relation to training, acceptability, implementation and outcomes were the main focus of the review team. The key evaluation questions were informed by the Victorian Trial evaluation project.[4]

Training, acceptability, implementation and outcomes are all important elements of the Safewards Theory of Change which aims to engrain de-escalation techniques into the everyday work practices on participating wards.

Training

- How effective was the ACT training program in building participants knowledge and confidence in using the Safewards model and 10 interventions?

Acceptability and applicability

- How acceptable was Safewards to consumers in the wards participating in the ACT wards trial?
- How acceptable and applicable was Safewards, according to staff participating in the ACT Health Safewards trial?

Implementation

- How was the implementation of Safewards perceived among relevant stakeholders, including non-participating nurses and midwives?
- How was Safewards implementation enabled and impeded?
- Did the participating wards achieve fidelity with the Safewards interventions, during and beyond the trial phase?
- How have the ACT-specific rollout adaptations due to COVID-19 impacted on the delivery of the Safewards program?

Outcomes

- Was Safewards effective in reducing containment (seclusion events) of consumers in the Safewards ACT trial wards?
- How did Safewards impact on staff and consumer experience of safety and conflict in participating wards?
- How have the ACT-specific rollout adaptations due to COVID-19 impacted on the outcomes of the Safewards program?

Methodology

The Safewards Model of Care (MocC) implementation was assessed based on three main elements:

- Project documentation reviews;
- Nurses and midwives survey results; and
- Project stakeholder interviews.

The next three sections report review findings under these headings.

Project documentation review

The "Safewards" project team based at the Office of the Chief Nursing and Midwifery Officer at ACT Health provided the Policy Design and Evaluation (PDE) team access to relevant project documentation.

The Safewards project team also provided information on training day participants, trial focus group data collected from Safewards nursing staff and status reports on participating wards.

Pre-implementation training

Initial training had been planned for March 2020 but a different approach had to be developed due to the first COVID-19 outbreak occurring. Consequently, training was delivered using a mixed mode of delivery using both face-to-face and online modes.

A training day for Safewards leads and other relevant stakeholders was carried out face-to-face to familiarise participants with the 10 interventions and to enable them to further build capability in their relevant healthcare setting.

Some of the training was conducted online, with the trainer delivering online modules via Webex to the group throughout the day. Whilst the TASC Project Team facilitated each training day, conducting group activities to strengthen knowledge and learning of concepts from the training.

It is worth noting that this added to the complexity of delivering the Safewards model in the ACT setting.

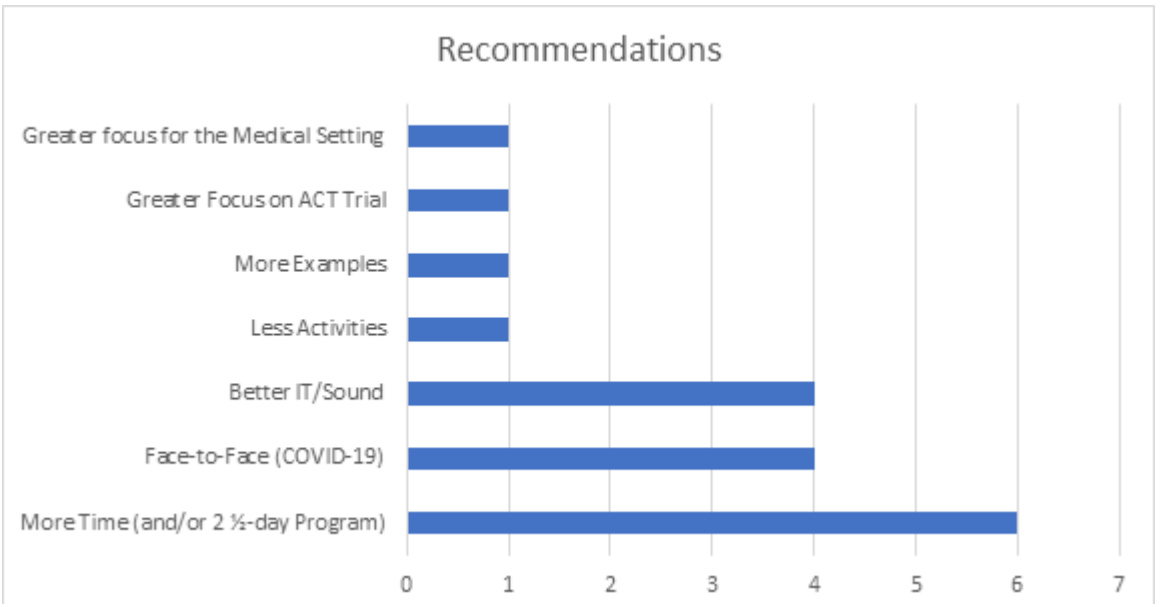
A pre-training day survey determined that 60 per cent of workshop participants had undertaken previous training in clinical aggression prior to being involved in Safewards, but a third of Safewards champions had not read any material about Safewards before the training day. More than 60 per cent of the participants had responsibility for training other staff members in the future.

After the training day, participants recommended more time for the training program and a face-to-face implementation for further workshops.

Post-training session, Safewards leads were expected to go back to their respective wards and work with their staff to implement the model and 10 interventions.

After the training day, posters were placed on the participating wards to further inform staff about the Safewards interventions.

Figure 2: Post-training day recommendations



Trial phase focus groups

The project team also conducted focus groups with nurses and multidisciplinary staff working on each of the participating wards to elicit their attitudes towards the Safewards model and how it functioned in practice on their wards. Staff members participated in groups of 6-8 nurses during breaks in their workday.

Staff discussed issues in relation to changes on their ward as a result of Safewards, their roles, benefits of and issues with the model, and what their advice would be to new staff members starting out applying the interventions. Furthermore, focus group participants were asked how Safewards should look like in 12 months' time and how benefits could be strengthened.

While most sessions were conducted by the Safewards project team, PDE team members attended one focus group session and consider the presented results as plausible and in line with other data sources further discussed in this report.

Relevant findings

- *Visual cues and materials* were considered important for atmosphere on the participating wards;
- *Orientation and inductions* were continuously practiced on the participating wards;
- *Leadership* was important for modelling expected behaviour by setting expectations of staff members and speaking about Safewards on a regular basis. In addition, Safewards champions also act as mentors for staff, patients, students and families;
- *Language and mindfulness* were important factors to convey the aims of the Safewards interventions. Consistent messaging and positive words are highlighted as important components of the Safewards program;
- More frequent *Staff interactions* were highlighted, with doctors attending mutual help meetings;
- Increased *Communication* between patients, family and staff was noted;
- Reducing *Power imbalances* between patients-staff and staff-staff by fostering a culture of collaboration;
- *Reduction of Occupational Violence (OV)* incidents were mentioned anecdotally;
- Validating *Ward difficulties* to acknowledge issues were seen as important;
- The need for sustainable *Resourcing* came up repeatedly;
- To have realistic *Timeframes* for implementation; and
- To consider issues with *Workload* and *Staffing* that can have implications for every staff member being able to consistently implement all required interventions.

Status reports

All participating wards delivered regular trial status update reports between February and May 2021. The participating wards used Safewards prompt sheets and fidelity checklists to record interventions and activities.

The status reports contained information on:

- Team member names;
- Documentation of all activities, including education delivered and interventions commenced;
- Planning for the coming month;
- Barriers;
- Wins; and
- Financial concerns and reporting issues.

Barriers included ambitious timelines, difficulties achieving education for all non-permanent ward staff during busy ward times, Safewards leads and senior nurses not being available for all the meetings with a full acuity and patient load. In addition, there have been some implementation delays reported due to delays in financial resources to support the activities. Some wards also reported getting other medical disciplines involved at all times and in some cases, staff were reluctant to provide personal information to patients.

"Wins" recorded on wards included the inclusion of study days for Safewards leads and champions.

One of the medical wards also independently initiated a WhatsApp group chat to supplement training efforts, including circulating short videos on how to implement the Safewards interventions.

The same ward also developed step-by-step guides to assist staff to plan implementation, in particular for new Champions.

Overall, staff were positive about the Safewards interventions, feedback from patients had been positive, that some allied health staff had become involved, and staff excited to have calm down methods at hand.

Status reports have been a valuable source of information and useful for monitoring the progress of implementation activities.

RiskMan data

RiskMan data records incidences of violence in healthcare systems. Data on incidents was not fine grained enough to allow for inclusion on how many occasions of violence occurred on participating as opposed to non-participating wards. Furthermore, this review did not consider the impact of Safewards implementation on incidents involving occupational violence.

Nurses and midwives survey results

The results presented in this section are based on a survey of nurses and midwives in the ACT public health system that was part of the recently completed, broader evaluation of the ACT Government's *Nurses and Midwives: Towards a Safer Culture* (TASC) Strategy. The ACT Safewards trial was an important component of the TASC Strategy.

Questions in the survey were adapted from relevant national and international literature and were refined through an iterative process with significant input from the TASC Project Team and TASC Steering Committee members.

The survey consisted of 30 closed and open-ended questions assessing knowledge of TASC priority actions and initiatives, experience of occupational violence (OV) and challenging behaviours in the workplace, and general perceptions of safety in the workplace.

The questions were compiled and collected in the SurveyMonkey survey software and administered via the ACT Health, Canberra Health Services (CHS) and Calvary Public Hospital communications teams to nursing and midwifery staff members. In addition, the survey was sent out via the Australian Nursing and Midwifery Federation (ANMF) to the Union's ACT members.

The survey was opened on 30 June 2021 and closed after two weeks on 7 July 2021. In total, 293 responses from nursing and midwifery staff were collected, representing a sample of around 4 per cent of all nurses and midwives in the ACT health sector.

Safewards awareness

Among our survey respondents, 30 per cent were aware of the Safewards Model of Care, and 13 per cent of respondents had worked on a Safewards ward in either Calvary Public Hospital or Canberra Hospital.

Conflict and containment

When Safewards nurses were asked whether Safewards has had an impact on conflict and containment (restrictive practice) events in their workplace, 56 per cent responded that it did, while 25 per cent did not agree and 18 per cent were unsure.

Clinical staff perceptions of Safewards

Safewards nurses also generally believed that their colleagues had a positive attitude towards the Model of Care (64 per cent), while 11 per cent of respondents thought that staff had a rather negative perception of the program and its interventions. The remaining 25 per cent respondents were either unsure or neutral on whether Safewards was well received among staff.

The high proportion of nurses believing their colleagues had a positive attitude towards Safewards supports the collaborative aspect of the Safewards Model of Care in the clinical context.

Patient/carer perceptions of Safewards

As patient and/or carer participation is an important component of the Safewards Model of Care, nurses were asked whether they had noticed any responses or feedback from healthcare consumers and their carers.

Overall, 43 per cent of Safewards nurses had heard positive consumer/patient responses, another 3 per cent had received negative responses, 28 per cent were unaware of patient feedback and 26 per cent were unsure. This result indicates that more feedback from patients and carers should be collected in a more formal manner, and results should be disseminated more widely on Safewards participating wards.

Managerial support of OV reduction

In addition to Safewards specific questions, survey respondents were also queried on whether their manager had spoken to them about OV. As the Safewards interventions aim to reduce safety risks to nurses and other clinical staff, they effectively form part of the broader series of ACT Government initiatives addressing OV.

Overall, similar proportions of Safewards (67 per cent) and non-Safewards staff (65 per cent) had been spoken to by their managers about OV.

The survey did not collect more detailed information about these conversations, such as their frequency or the content of the discussions. It is possible, for example, that staff on Safewards wards had more frequent, or qualitatively different discussions about OV with their managers; however, data to support conclusions on these aspects are not currently available.

Perceptions of Leadership support to reduce OV

Safewards nurses were more likely to agree that there was strong leadership culture in their organisation to support activities (52 per cent) to reduce OV than those who worked on non-participating wards (30 per cent). This is a significant result.

As Safewards aims to support culture change in the clinical context towards an overall safer workplace and place of treatment for patients, this result is a promising indication that Safewards wards may be paying more attention to addressing OV than other wards.

Perceptions of Workplace Safety

While the survey found similar proportions of Safewards and non-Safewards staff agreed that their workplace overall was safe (41 per cent, respectively), a significantly larger share of non-Safewards staff thought that their workplace was *unsafe* (37 per cent versus 23 per cent). Again, this supports the notion that Safewards has a positive impact on workplace safety as perceived by staff.

Perceptions of Workplace Quality

As a result, more Safewards-affiliated staff considered their organisation to be a great place to work (51 per cent) than those who did not work in the context of the model (44 per cent).

Summary

Generally, the survey demonstrates that despite the smaller number of staff currently working on Safewards-associated wards, the Model of Care is well received and appears to have contributed to reducing instances of containment and restrictive practices. Both staff and patients and their carers seem to react positively towards the interventions.

Importantly, a greater proportion of Safewards staff think that there is a strong leadership culture to address OV in their workplace than nurses working on non-participating wards.

It should be noted that while these results give some encouraging, broad indications of possible impact, they are really a first set of findings and as such do not represent a rigorous impact assessment of how the Safewards Model of Care has impacted over time.

The analysis presented here also cannot adjust for a variety of plausible confounders or influencing factors, such as (for example) whether more nurses from Safewards wards that had a positive experience with the Safewards trial responded, which could introduce a bias.

In addition, the survey data are not at the level of disaggregation to allow interpretation of the impact of implementing specific interventions prescribed by the Safewards Model of Care.

To gain a more nuanced understanding of such issues a series of interviews with stakeholders involved in the Safewards Implementation processes was carried out.

Stakeholder interviews

Interviews with ten Safewards stakeholders, including Safewards leads of all four trial wards, were conducted over a two-week period in October 2021.

The interviews were held online on either the Microsoft Teams or Webex videoconferencing softwares and recorded with permission of interviewees. No interviewee objected. The recordings were transcribed and imported in NVIVO, a software program used for text and other qualitative source analysis.

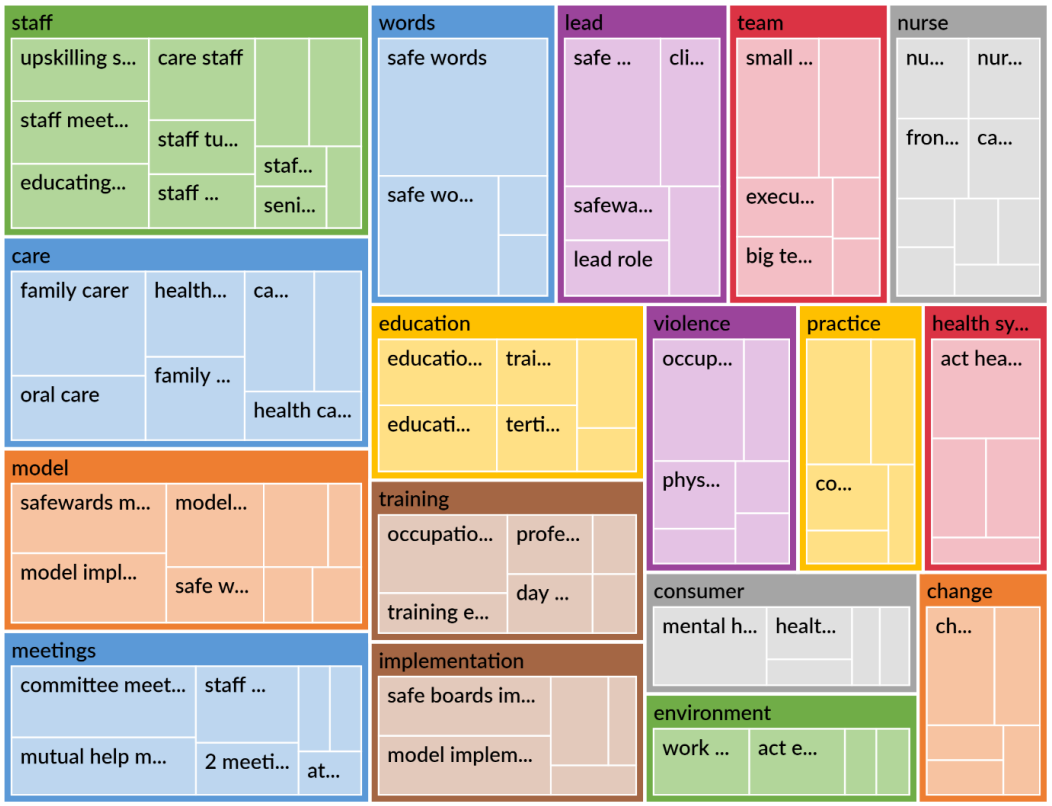
- The word frequency analysis suggests that the Safewards Model of Care places people and staff front and centre to achieve safer outcomes.
- In addition, a thematic analysis was performed in NVIVO, based on system auto-coding analysis. The following topics emerged from the transcripts:
  - The importance of staff-driven initiatives in the Safewards model of care;
  - Safe words that can reduce violent incidents;
  - The role of Safewards Leads to model positive behaviours;

- The role of teams and collaborative action in reducing harm;
- The role and expectations of nurses within the context of staff and patient safety;
- How care influences safety creation processes;
- How health systems influence outcomes;
- Professional practice, education and training are all important for Safewards implementation;
- The importance and difficulty of fostering culture change; and
- How meetings in the Safewards context foster collaborative approaches.

Figure 3: Stakeholder interviews word frequency analysis

In addition to word frequency and thematic analysis, the PDE team mapped the *Key Evaluation Criteria* against the thematic analysis to further investigate how Safewards was implemented.

Figure 4: Stakeholder interviews thematic analysis



Aims and benefits of Safewards

Interviewees mentioned multiple aims and benefits of the Safewards program. Overall, interviewees understood that there were several aims of the Safewards trial, with the most important being around safety outcomes for consumers and staff (including minimising physical and chemical restraint). In addition, other benefits considered included the boosting of staff morale and the creation of partnerships with patients and their families.

Implementation support

Interviews revealed that Safewards implementation is not a one-size-fits-all approach and needs to be customised to differing circumstances. In some wards, implementation support was required while other wards took ownership of the implementation and customised the model to their own needs. Different areas appear to have specific needs in terms of the level of support they need to implement Safewards successfully:

- A suggestion from one ward was that they required additional assistance, such as a support person who could come into the area one day per week to help with the rollout.
    - The review team concluded that there is a difficult balance to be struck in terms of the level of external support to provide, as the model itself aims to foster

independent adoption of the model once staff have received initial training and are sufficiently upskilled to implement it on a sustainable basis.

> A physical booklet as a handy reference guide, ideally written to the specific rollout environment (i.e., ward) would support implementation processes. If there was a dedicated implementation staff member, they could do this as part of their job.

Perceived impact on ward culture and safety

Interviewees spoke of noticeable changes, e.g., observing staff members using the techniques they were taught under the Safewards model. Some interviewees noted a reduction in seclusion events in mental health despite this being a high acuity period (from 25-30 per month down to zero over the previous three months). Multidisciplinary teams also wanted to come on board quickly, including many allied health professions (e.g., speech pathologists, physiotherapists, occupational therapists).

Enablers and barriers to implementation

COVID-19 threw up significant barriers for implementation, including issues with spending as the shops were closed (some funds were unable to be expended). Interviewees mentioned that the pattern of clinical presentations was potentially different to what would ordinarily be the case, i.e. more high acuity patients and a generally more stressed environment, and limited ability of carers and families to interact due to restrictions on the number of visitors and visiting times.

General pressures included having the time to roll Safewards out in an already very busy working environment. In terms of staff allocation, interviewees thought it was important to 'protect' some time for Safewards-relevant learning, they had to be mindful of rosters to know who was working at particular times and to ensure all staff were captured. Some interviewees perceived the intervention implementation as extra work while others did not.

The critical role of leadership was mentioned as an enabler. Some interviewees said that their senior leaders were on board, and this really helped with the implementation processes. Their managers would attend meetings, participate 'on the floor', help with reminders which remediated the challenge of trying to motivate all Safewards staff members.

Another crucial factor was the time required to involve staff in the Safewards implementation processes. While staff in one ward "really loved it", the evidence from other wards appears to suggest that staff members can be sceptical initially and consider the associated interventions as an additional burden. The interviewees' responses indicated, however, that where this was the case the Safewards approach quickly brought people on board:

> In particular, giving staff some autonomy and encouraging them to come up with their own ideas for how to implement particular elements of the program helped secure buy-in (e.g., fridge magnets with photos of staff members; 'connecting' the bees with the sunflowers, etc.).

Patient and carer feedback

Interviewees noted that they had only received highly positive feedback from a range of sources, importantly consumers. Some consumers in fact appeared to know about Safewards already and were very keen to participate in implementation processes. Some anecdotal evidence also suggested that interventions such as "Soft Words", "Positive Words" and "Know Each Other" have numerous benefits for patients and their carers.

Scope for improvement

Different aspects of the Safewards model led and lagged in different environments, but "Know Each Other", "Calm Down Methods", and "Discharge Messages" were interventions where the interviewees strongly agreed that the implementation of the Safewards model has been successful. One area that appears to have had issues with implementation was "Bad News Mitigation", in one instance a comment was received that this relies on participation of doctors on call and this had been difficult to arrange.

Discussion

Training

Both project documentation and stakeholder interviews indicate that the "Train-the-Trainer" training program was well received by participants. However, some Safewards staff indicated that due to staff turnover on the wards more continuous training could have been provided to new starters. Some interviewees also thought that additional support for implementation would have been beneficial to train staff in implementation activities.

Acceptability and applicability

Survey and interview results suggest that staff overall considered the Safewards model to be a good intervention, with only a small proportion expressing concerns about additional burden on day-to-day business.

Just below 50 per cent of staff responding to the survey had received positive feedback from patients or carers, however the remainder had not received any feedback. Collecting and disseminating more structured feedback information to support the anecdotal evidence.

Implementation

While some interventions on medical wards were changed to suit specific circumstances, and therefore did not adhere completely to the original Safewards model, these changes were initiated to reflect realities on the specific participating wards. Some of the intervention implementation activities were also slowed down due to Covid-19 protocols in hospital settings.

While these modifications made sense to participating staff, it renders assessing implementation fidelity more complex due to comparison issues. Comparing participating

wards and attributing safety outcomes and impacts can be challenging when interventions differ between clinical settings.

The Safewards Model of Care was well perceived by most stakeholders, including health care consumer representatives and clinical administration staff. While participating nurses were generally enthusiastic in relation to the interventions, some concerns relating to additional burden on workload were relayed during interviews.

Anecdotal evidence provided in interviews suggests that non-participating nurses and midwives were interested in Safewards and in working in associated wards; however, survey results indicated that only 30 per cent of all nurses were aware of Safewards and its interventions and only 13 per cent of nurses and midwives had worked on a Safewards ward in either Calvary Public or Canberra Hospitals.

While the Safewards Roadshows have been an important initiative to foster interest and to gain awareness, more education and promotion of Safewards should be considered. In addition, collecting regular survey data to gather structured data on both participating and non-participating staff would enhance intelligence on staff attitudes.

This data could also add further insights into enablers and barriers to Safewards implementation and potential outcomes. Interviewees indicated that the main enablers for the Safewards model are leadership and staff attitudes.

It was reiterated that implementation success depends largely on Safewards leads promoting interventions and modelling expected behaviours and activities. However, staff engagement was often impeded by time pressures, staffing shortages and general challenges of clinical wards during COVID-19.

Outcomes

Interview participants working on participating wards thought that Safewards reduced containment, including seclusion events of consumers. Furthermore, some of the initiatives specifically on medical wards seemed to have positive effects on both staff and consumers in terms of feeling more connected to each other. However, the survey results indicate that there was no significant difference in workplace safety perceptions between participating and non-participating Safewards staff.

Further rigorous data collection comparing staff in participating and matched non-participating wards would be beneficial to understand the contributions of the Safewards Model of Care to perceptions of workplace safety in clinical settings.

The results suggest that the changes made to interventions specifically on medical wards did not affect the outcomes of the Safewards program overall. While implementation fidelity Safewards has been highlighted as an important factor in the literature, a more pragmatic approach to implementing specific initiatives where appropriate seems to have served the ACT well.

Recommendations

Recommendation 1: Expand the Safewards implementation to additional wards

The review finds that there is very little potential 'downside' to rolling the program out to additional wards (no harm), but significant benefits which are also in line with wider strategies on OV and culture change across the public health system.

Having demonstrated that Safewards can be implemented safely in the ACT, further rollout is therefore recommended subject to Recommendation 6 which seeks to ensure that no wards are left behind or unduly burdened by such a rollout.

Recommendation 2: Provide continuous training and support for new staff and non-participating nurses

New staff members and non-participating nurses need to have a strong understanding of the model and associated interventions. Consider additional trainer resources for wards facing issues implementing the interventions.

Recommendation 3: Provide training, placement and/or staff rotation opportunities to improve awareness and knowledge

Opportunities to work on wards that have successfully implemented Safewards would lift knowledge and awareness across wards, which would also support professional competencies and a more standardised approach to the management of patients.

Recommendation 4: Engage "Executive Safewards Ambassadors" to increase leadership visibility and provide critical support to their middle managers

"Safewards Champions" were identified at the beginning of the trial phase, but ongoing engagement of executive leaders is crucial to promote awareness, uptake, and acceptance.

Recommendation 5: Collect structured data in relation to staff and healthcare consumers' attitudes

While anecdotal data collected in focus groups and interviews can provide evidence of attitudes towards Safewards and associated interventions, a structured data collection plan including administrative and survey data would strengthen evidence and allow for impact evaluations further down the road.

Recommendation 6: Identify "Pathways to Safewards"

Wards which are not quite ready to roll out Safewards may benefit from a stepped implementation process starting with an initial rollout of perhaps just one or two of the 'easier' interventions rather than the complete set of interventions.

Appendix A: Project documentation

Table A1: Project documents

Project stage	Activity
Planning Phase	Champions Training Day Resources
Planning Phase	Decision on Trial Site Locations
Planning Phase	Safewards Promotional Material
Trial Phase	Focus group data
Trial Phase	Safewards Status Reports
Trial Phase	Safewards Engagement activities

Appendix B: Survey data

Figure B1 Perceived positive Safewards impact on containment and restrictive practices

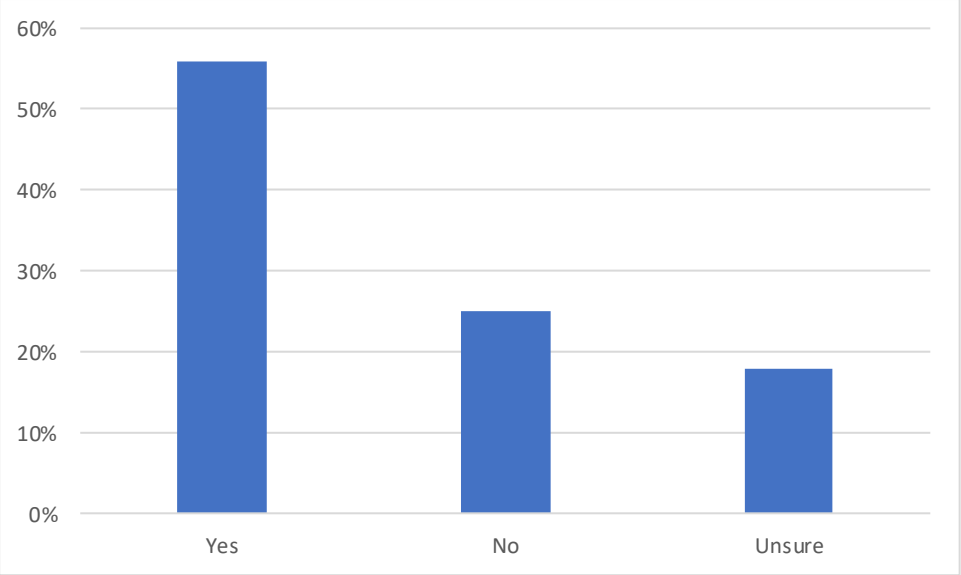


Figure B2 Staff perceptions of the Safewards Model of Care

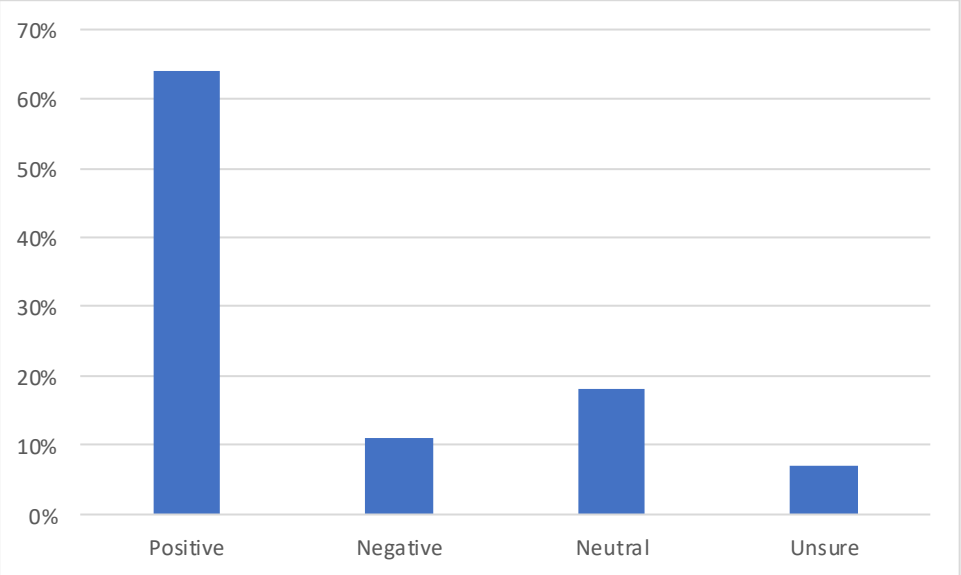


Figure B3 Perceived patient/carer feedback of the Safewards Model of Care

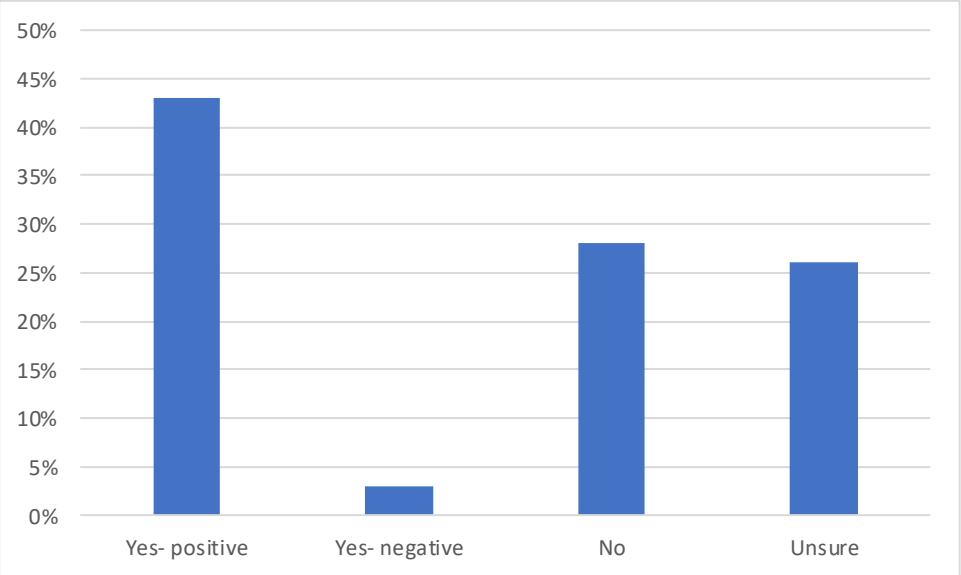


Figure B4 Staff/Manager conversations about Occupational Violence (OV)

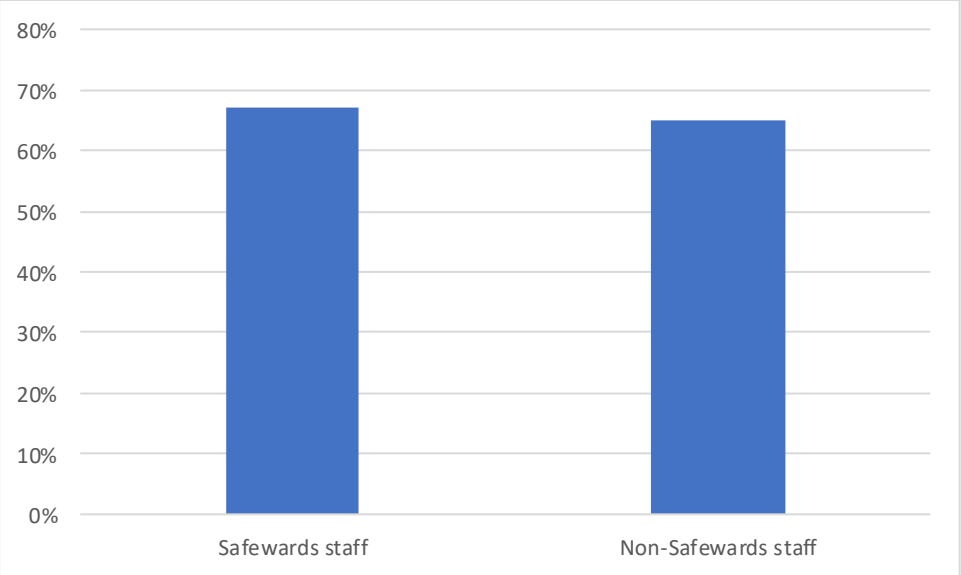


Figure B5 Agreement with a strong leadership culture on OV prevention

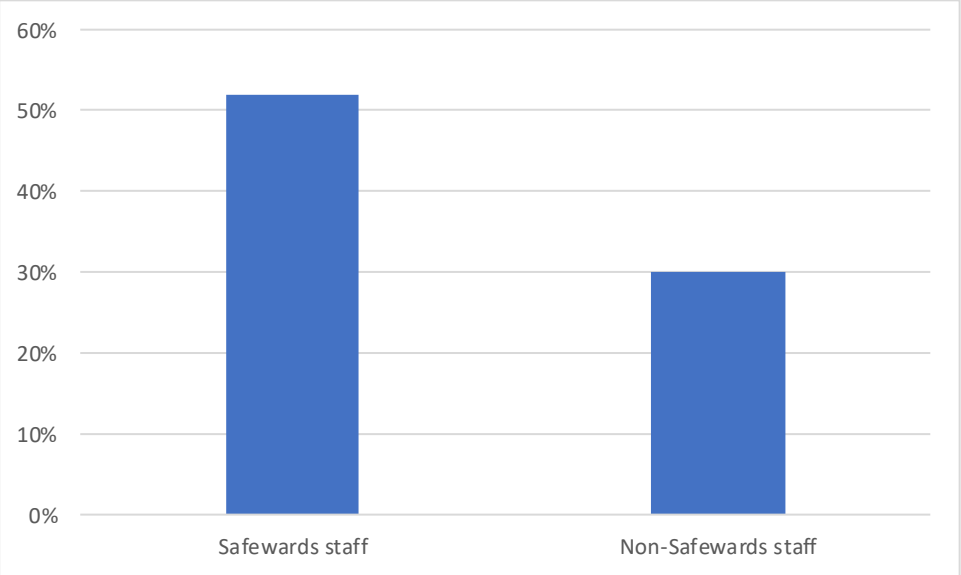


Figure B6 Agreement with organisation being a good place to work

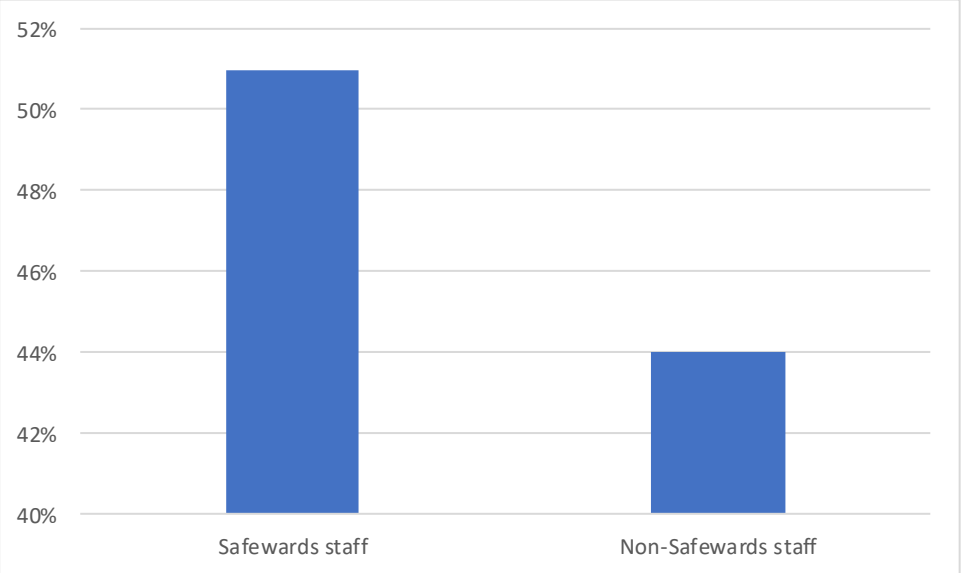
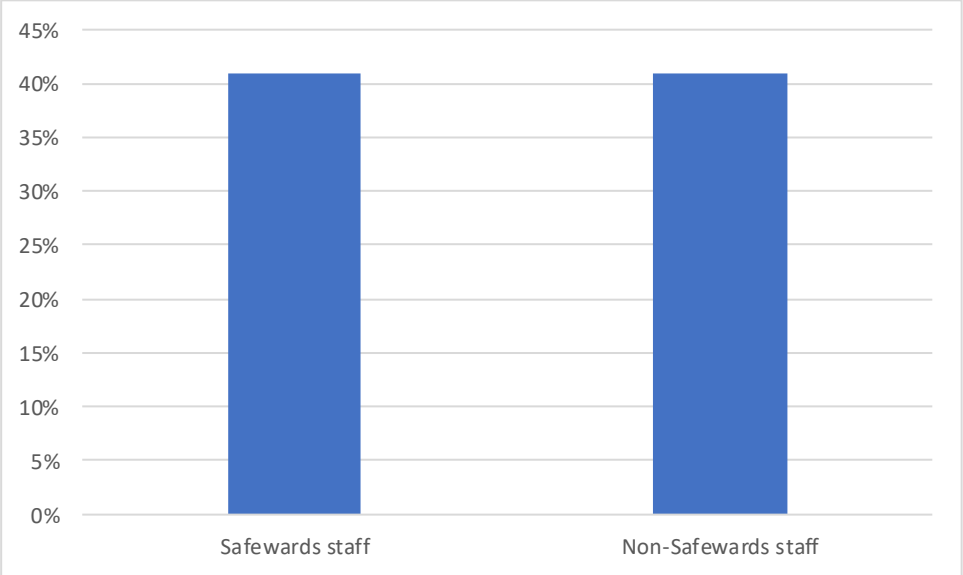


Figure B7 Do you feel safe in your workplace? (Safewards vs non-Safewards staff)



Appendix C: Stakeholder interviews

Survey questions

The survey questions have been developed by the ACT Health Safewards implementation team:

1. *How suitable was the Safewards Model and Interventions from your point of view?*
2. *Which Safewards interventions do you believe have been successfully incorporated?*
3. *In which ways did implementing Safewards require changes to be made to the way you worked?*
4. *What do you believe your role as a Safewards Lead is in implementing Safewards? (for Safewards leads)*
5. *Describe the enablers for implementing Safewards.*
6. *Describe the barriers for implementing Safewards.*
7. *How do you believe staff in your ward/division perceived Safewards?*
8. *Have you noticed or heard consumer/patient responses to Safewards, if so, what have they been?*
9. *Do you feel Safewards has had an impact on conflict and containment (restrictive practice) events in your workplace? If so, please provide examples.*
10. *What would be your suggestions to new Safewards Leads of other services implementing Safewards?*
11. *What are your suggestions for improving the implementation of Safewards in the ACT?*
12. *Please provide a list of core components that you believe need to be in place to support implementation of Safewards.*
13. *Now that the Safewards trial is coming to an end how do you perceive the Safewards Model and Interventions can be sustained?*

References

1. The Royal College of Nursing. Principles of nursing practice, available for download from https://www.rcn.org.uk/professional-development/principles-of-nursing-practice, 2021.
2. Bowers L, Alexander J, Bilgin H, et al. Safewards: the empirical basis of the model and a critical appraisal. *Journal of Psychiatric and Mental Health Nursing* 2014; **21**(4): 354-64.
3. Bowers L, James K, Quirk A, Simpson A, Stewart D, Hodsoll J. Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies* 2015; **52**(9): 1412-22.
4. Fletcher J, Spittal M, Brophy L, et al. Outcomes of the Victorian Safewards trial in 13 wards: impact on seclusion rates and fidelity measurement. *International Journal of Mental Health Nursing* 2017; **26**(5): 461-71.
5. Gerdtz M, Daniel C, Jarden R, Kapp S. Use of the Safewards Model in healthcare services: a mixed-method scoping review protocol. *BMJ open* 2020; **10**(12): e039109.
6. Finch K, Lawrence D, Williams MO, Thompson AR, Hartwright C. A Systematic Review of the Effectiveness of Safewards: Has Enthusiasm Exceeded Evidence? *Issues in Mental Health Nursing* 2021: 1-18.
7. Davies B, Silver J, Josham S, et al. An evaluation of the implementation of Safewards on an assessment and treatment unit for people with an intellectual disability. *Journal of Intellectual Disabilities* 2020: 1744629520901637.
8. Higgins N, Meehan T, Dart N, Kilshaw M, Fawcett L. Implementation of the Safewards model in public mental health facilities: a qualitative evaluation of staff perceptions. *International Journal of Nursing Studies* 2018; **88**: 114-20.
9. Kennedy H, Roper C, Randall R, et al. Consumer recommendations for enhancing the Safewards model and interventions. *International Journal of Mental Health Nursing* 2019; **28**(2): 616-26.
10. Gooding P, McSherry B, Roper C. Preventing and reducing 'coercion' in mental health services: an international scoping review of English-language studies. *Acta Psychiatrica Scandinavica* 2020; **142**(1): 27-39.

ACT Government

Policy Design and Evaluation Team

Post-Implementation Review of the *Safewards* Model of Care Trial in the ACT

Policy Design and Evaluation Team, Policy and Cabinet Division
Chief Minister, Treasury and Economic Development Directorate

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