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Report to

Chief Mental Health Nurse

Department of Health & Human Services, Victoria

Safewards Victorian Trial

Final Evaluation Report

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THE UNIVERSITY OF MELBOURNE

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Acknowledgements

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Executive Summary

Background

Safewards is a program that consists of a conceptual model and a set of 10 interventions, developed in the UK for use in acute psychiatric wards (Bowers 2014). The Safewards model explains the relationship between conflict and containment in this setting, highlighting opportunities for nurses to intervene, both to prevent conflict and to respond in least restrictive ways. A package of 10 interventions was implemented in 2013 in a large cluster randomised controlled trial in 31 adult acute wards in England (Bowers *et al* 2015). The experimental trial in England showed that Safewards was associated with both reduced conflict and reduced use of seclusion.

The ***Victorian Safewards Trial*** seeks to: apply the Safewards model; implement the same 10 Safewards interventions in Victorian public mental healthcare settings; and extend the interventions to aged persons' and adolescent mental health wards and to secure extended care (SECU) settings. It was a collaborative effort between the Department of Health and Human Services and seven public mental health services. The project comprised a *Training phase* over a four-month period from November 2014 to the end of February 2015, a *Trial phase*, conducted from March 2015 to the end of May 2015 and a *Sustainability phase*[1], from June 2015 to April 2016.

Reporting on evaluation

This final report sums up findings from all phases of the Victorian Safewards Trial, but focuses in particular on outcomes in terms of: 1) seclusion events, 2) staff and consumer perceptions of Safewards' impact, and 3) the sustainability of Safewards across the participating Victorian inpatient wards.

The evaluation of the Safewards Victorian Trial was conducted by researchers at the Centre for Psychiatric Nursing, the University of Melbourne. A program-logic was developed at the outset, to define the objectives of the project. A mixed method design and multiple data sources were used to determine if the objectives of the Trial were met. Data included: Safewards fidelity measures based on observation by evaluators, several staff and consumer surveys, organisation-level diaries of project activity, and state wide data regarding seclusion events in all inpatient settings.

The first report for the project was produced in **March 2015**. It identified trial preparations within organisations, providing preliminary data analysis of the Safewards pre-training survey and the Safewards readiness checklist. The second interim report, provided in **September 2015,** focussed on the process evaluation with analysis of: staff knowledge, attitudes, and motivation regarding Safewards pre- and post- training; and fidelity with the Safewards interventions per-unit, over three time points in the intervention period.

This final report focuses on the outcome evaluation, with detailed analysis of: seclusion events pre- and post-Safewards implementation, sustained fidelity with the Safewards interventions per-unit over a one year period, and quantitative and qualitative staff and consumer feedback about the experience, acceptability and sustainability of Safewards. The background and methods sections in this report provide detail relevant to evaluation of outcomes, impact and sustainability.

This report answers six major evaluation questions:

- Was Safewards effective in reducing containment (seclusion events) of consumers in the Safewards Victorian trial wards?
- How did Safewards impact on safety and conflict in participating wards?
- How acceptable was Safewards to consumers in the wards participating in the Victorian Safewards trial?
- How acceptable and applicable was Safewards, according to staff participating in the Victorian Safewards trial?
- How was Safewards implementation enabled and impeded?
- Did the participating wards achieve fidelity with the Safewards interventions, beyond the trial phase?

[1] In June 2015 the outcomes and sustainability phase of the project was extended to April 2016, in negotiation with services and evaluators.

Key findings of the Victorian Safewards Trial evaluation

Key findings regarding effectiveness and impact

Outcome evaluation: Seclusion rates were not substantially reduced during the Safewards trial

- The Safewards wards did not reduce their use of seclusion in the trial period, and seclusion rates were comparable between Safewards and non-Safewards wards in that period
- Seclusion rates in Safewards wards trended downwards, from pre-Safewards (11.67 events per 1000 occ bed days) to follow up (7.511, p=0.19)
- The youth wards achieved a significant reduction in use of seclusion, from pre-Safewards to followup compared to non-Safewards wards (difference of 11.21, p=0.01)

Impact evaluation: Consumers (n=75) **and staff** (n=103 surveys, 24 staff in focus groups) **considered that Safewards resulted in improved safety and decreased conflict**

- Consumers across participating wards considered that Safewards resulted in improved safety (55% usually or always) and decreased verbal conflict (45% sometimes to always) with staff and between consumers
- Staff across participating inpatient wards considered that Safewards resulted in improved communication and decreased conflict and confrontations with consumers
- Consumers reported an increased sense of optimism (81% sometimes to always) and mutual support during their inpatient stay
- Consumers and staff experienced Safewards as increasing the respectful interactions between them

Key findings regarding training and implementation process

Training evaluation: The Victorian Safewards training approach was effective for preparing staff across trial sites.

- The majority of staff (414+) across sites participated in central and/or local Safewards training, made significant gains in knowledge, confidence and motivation to use Safewards, through the training and implementation processes.
- The train-the-trainer approach produced an array of modular training resources – power point slides and workshop activities – that were readily available to implementation leads and taken up in local services.
- Central train-the-trainer workshops were highly valued by participants.
- Train-the-trainer delivery - from central workshops to local delivery - gave rise to diverse local Safewards training delivery modes

Implementation evaluation: Local implementation processes were associated with a range of enablers & barriers

- Engagement of staff at several levels of the organisation impacted upon implementation
- Engagement of a leader and key group of staff inside the wards that were positive and supportive of the Safewards model facilitated implementation
- Existing processes in many health services were built upon to support implementation
- Operational constraints to implementation were: tight timeframes for training and implementation, operational barriers to purchasing items
- Staff attitudes featured as powerful enablers **and** barriers to implementation of Safewards:
    - Staff described negative attitudes regarding self-disclosure and low levels of trust among a minority of colleagues, also rigidity about rules and a lack of skills or willingness to negotiate with consumers
    - Equally, staff described positive attitudes and highly developed skills among colleagues in regard to de-escalation and creative problem solving, in highly challenging circumstances

Key findings regarding applicability, acceptability and sustainability

Applicability: The Safewards model made sense to staff, most interventions were keenly taken up by staff (n=103), **and consumers enthusiastically engaged with several interventions** (n=72)

- Staff recalled using all the Safewards interventions and doing so 'usually' or 'always'(70%); staff described the interventions as simple and relevant
- *Reassurance, calm down* and *positive words* were reported as most frequently used by staff
- Consumers provided detailed positive feedback about the interventions they actively engaged with, most notably: *mutual help meetings, calm down* & *discharge messages*
- Consumers were interested in knowing more about the background to Safewards and Consumer workers were keen to contribute to staff training and to championing interventions

Acceptability: Safewards was highly acceptable to staff (n=103) **and consumers** (n= 72)

- Staff affirmed the Safewards model as highly relevant and important to their work in inpatient settings
- The majority (70%) of staff reported suitability of the model and interventions as 'very good' or 'excellent'
- *Talk down, calm down* and *positive words* interventions were rated by staff as extremely highly suitable
- Staff considered that some interventions needed modifying, mainly in language to fit well with practice
- Consumers felt that Safewards matched well with their own values
- Consumers felt affirmed in their ability to contribute positively to each other's wellbeing

Sustainability evaluation: Fidelity was achieved to a very good standard in the trial period and to an excellent standard in the sustainability period.

- Fidelity increased across all but 3 wards over the trial period of three months and further for all 14 monitored wards over the sustainability period of 9 months.
- The average fidelity through the trial of 5.9/10 and end point fidelity of 6.8/10 is comparable to the level of fidelity in at the endpoint in the UK research trial, making it possible to soundly compare effects and impacts between UK and Victoria in the outcome evaluation phase.
- The average fidelity achieved through the sustainability period is higher than the Safewards UK trial, suggesting that there are fewer barriers to sustaining Safewards once implemented than to introducing it.
- There was variation in fidelity between adult inpatient units and within participating organisations, which levelled out over the sustainability period.
- Highest fidelity ratings were achieved earliest and sustained most in youth units.
- High fidelity (>70%) was achieved by the end of sustainability period, in all 14 wards monitored.

Conclusions

- The trial does not show Safewards reduced the restrictive practice of seclusion across Victorian settings
- However, the seclusion trend (a non-significant reduction by the end of follow up) and the sub-group analysis (significant seclusion reduction for youth wards) supports a conclusion that Safewards *shows potential* to reduce restrictive practices in Victoria
- The consumer and staff responses provide a strong case that Safewards decreased conflict in Victorian settings
- In the view of these most important stakeholders, Safewards prevented conflict and improved communications, optimism and relationships among consumers and staff in inpatient settings
- The pattern of increasing fidelity, beyond the time frame of funding for project and key roles, is not common in implementations of practice change
- The high fidelity that was achieved suggests that it is vital to invest in the early (training and implementation) phase, in order for implementation of Safewards to be effective.

Recommendations from the Victorian Safewards Trial evaluation project

Integration of the findings from this evaluation brings together evidence of the full range of inputs, processes and outcomes that matter for all stakeholders. Out of these findings comes a list of empirically supported key ingredients, and a model, for future implementation of Safewards.

Recommendations for policy and governance:

1. Further implementation of Safewards should be supported in Victoria, with the aims of i) increasing safety, ii) improving communications and relationships in practice and iii) possibly reducing restrictive interventions in inpatient wards.
2. A reliable and feasible measure of conflict should be identified for routine use in inpatient wards, to i) increase understanding of this key issue for staff and consumers and to ii) support ongoing monitoring of Safewards.

Recommendations for future Safewards implementation processes:

3. Any proposals for Safewards implementation should include the **people**, **knowledge** and **support** elements featured in figure 1.

Figure ES:1 Key Safewards implementation elements

People

→Senior organisational buy-in initially & intermittent engagement in the year, to redress implementation barriers

→At least 2 mid-level change agents present in the ward, including: educator/s, a person with operational authority (eg Nurse Unit Manager (NUM), Associate Nurse Unit Manager (ANUM))

→A consumer consultant/peer worker, active with one or more interventions

→At least one of: an allied health staff member or medical staff member active with one or more interventions

→Intervention champions appointed, present & active on the ward (number is not determined) until intervention is embedded

Knowledge

→Strong understanding of the model & the interventions within all change agents

→Clear understanding of key concepts in the model within majority (>50%) of ward based staff, new & casual staff inducted/oriented to model & interventions

→Orientation to the model & aims among consumers & carers

→Explicit processes for adaption of training materials, prepared trainers

→Local knowledge of outcome data, regarding conflict & containment

Functional Support

→Training resources, schedule to train (& potentially test) knowledge at intervals

→a plan to fit training with existing mandatory schedule

→Dedicated budget for intervention items, plan for replenishing

→Explicit processes for considering adaption & fit of interventions with existing ward space, practices, documents, daily & weekly routines, policies

→ Safewards integrated into quality review, including KPIs,
a timeframe & an identified agent for fidelity monitoring & feedback

→Organisational link to another Safewards site

This model can be further refined with key personnel at current Safewards sites, and used as a resource to implementation in other wards and sites.

Chapter 1 Background

Outline of the Safewards model, intervention and the Victorian Safewards Trial

Safewards is the culmination of a 20-year program of research in the United Kingdom lead by Emeritus Professor Len Bowers, of the Institute of Psychiatry, Kings College London. The two vital components of Safewards are the model and the interventions. The Safewards model (Bowers 2014) explains the relationship between conflict and containment in acute inpatient psychiatric settings within public sector mental health services, highlighting opportunities for nurses to intervene, both to prevent conflict and to respond in least restrictive ways. The summary version of the model is shown here:

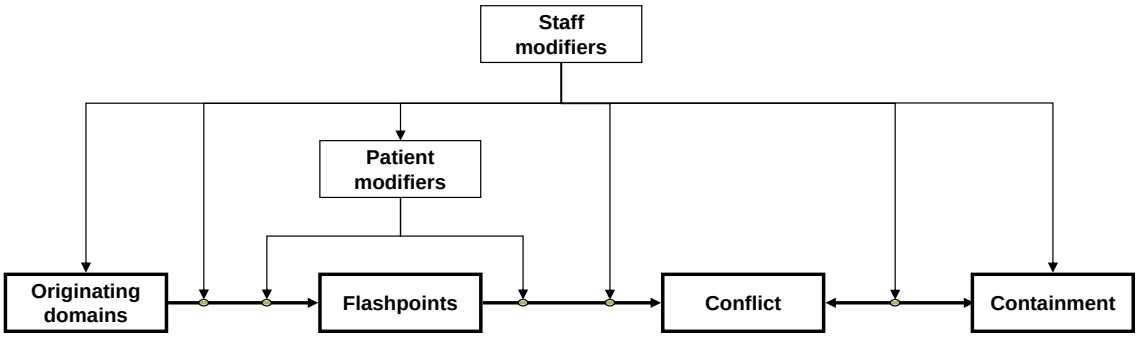


Figure 1.1: Safewards Model

A package of 10 interventions was implemented in 2013 in a cluster randomised controlled trial, in 31 adult acute adult wards in England (Bowers, James, Quirk, Simpson, Stewart & Hodsoll 2015). 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. The model and the interventions were described in detail in the first report, March 2015.

Over a decade, the Victorian Department of Health and Human Services has actively pursued a policy commitment to reducing seclusion in inpatient services (Hamilton & Love 2010). Victorian mental health services have achieved a substantial reduction in use of seclusion in the 5 years, whereby rates (reported as seclusion events per 1000 occupied bed-days) reduced from 13.58 in 2010-11 to 8.55 in 2014-2015 (Chief Psychiatrist 2015). However, it is a continuing quality objective for the government and for mental health services to absolutely minimise the use of restrictive interventions. In Victoria, this objective has most recently been pursued through an initiative called Reducing Restrictive Interventions (RRI).

The Victorian Safewards Trial was a major implementation project within the RRI initiative that aimed to: apply the Safewards model; implement the same 10 Safewards interventions in Victorian public mental healthcare settings; and extend the interventions to aged persons' and adolescent mental health wards and to secure extended care (SECU) settings. It was a collaborative effort between the Department of Health and Human Services and seven public mental health services. The Victorian 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. Rather, the Trial was devised to implement Safewards as an evidence-based psychosocial intervention in inpatient units, and to evaluate the process and outcomes. The Victorian Safewards Trial comprised a training and preparation phase, over a four-month period from November 2014 to the end of February 2015, a trial phase, conducted from March 2015 to the end of May 2015 and a sustainability phase, from June 2015 to April 2016.

The 10 intervention strategies included in the Victorian Safewards Trial are entitled: *Clear Mutual Expectations, Soft Words, Talk Down, Positive Words, Bad News Mitigation, Know Each Other, Mutual Help Meeting, Calm Down Methods, Reassurance* and *Discharge Messages*. The Victorian Safewards Trial explicitly extended implementation of the interventions into aged persons' and adolescent mental health wards and into secure extended care (SECU)

wards. Features of the seven participating Victorian area mental health services and the 18 trial wards are tabled below.

Table 1.1 Safewards trial sites

Service	Wards
Albury Wodonga Health Wangaratta	1 ward = Kerford Adult Acute Unit
Alfred Health Prahran	2 wards = Ground Floor & First Floor Adult Units
Bendigo Health Care Group	3 wards = Adult Acute/Alexander Bayne Centre, SECU/Vahland House, Aged Persons' Acute/ Marjorie Phillips Unit
Latrobe Regional Hospital Traralgon	2 wards = Flynn Acute Adult Unit & SECU
Melbourne Health / NWMH, Footscray, Epping & Lalor	4 wards = Orygen Youth Acute Unit, Northwest Adult Unit, Northern Adult Acute Units 1&2
Mercy Health, Werribee	1 ward = Adult Acute Unit
Monash Health Clayton, Dandenong & Cheltenham	5 wards = Stepping Stones Adolescent Unit, 1 Adult Acute Unit, 2 Youth Acute Unit, Aged Persons' Acute Unit & Alambee Aged Residential Service

Negotiation of contract arrangements for the Victorian Safewards Trial and for the evaluation commenced in October 2014. During the *training and preparation phase* (hereon referred to as ***Training phase***) a number of activities were conducted. The Victorian Department of Health and Human Services hosted three train-the-trainer workshops between December 2014 and January 2015, the Safewards project Leads and other health service staff (often Nurse Educators) attended the workshops. Participants from the workshops returned to their own health services to roll out localised training and preparation activities. Preparation activities in each ward included: identifying a champion for each of the 10 interventions; identifying processes whereby Safewards materials such as posters, folders, postcards and reminder notices could be produced; and establishing processes for incorporating interventions into practice.

During the *trial implementation phase* (hereon ***Trial phase***) all ten interventions were to be introduced in each ward. Implementation required particular activities for the champions of specific interventions and for all staff in the wards. Actions included: displaying various posters and folders in consumer areas and staff areas of the wards, adjusting the content of daily handover meetings, facilitating group meetings involving staff and consumers, and generating particular communications between consumers and staff.

In the final *outcomes and sustainability phase (**Sustainability phase**)* of the project, organisations focused on sharing learnings from the trial period and planning for and transitioning the leadership of Victorian Safewards, beyond the funded implementation project. Staff of participating wards engaged in focus group discussions, continuing orientation of staff and local monitoring of fidelity. Key Safewards leaders commenced meeting as a community of practice, comparing experiences and sharing resources.

In June 2015, the *Sustainability phase* of the Victorian Safewards Trial was extended through April 2016. The purpose of this extension was to enable all project stakeholders to consider the implementation experience, outcomes, decisions and implications, well beyond the trial implementation period. One organisation did not agree to participate in the extension of the project beyond the original project end date of July 2015, so did not engage with continued implementation and additional evaluation activities conducted after July 2015.

This report is provided after the *Sustainability phase* of the trial. Most of the detail provided in this background section and in the methods chapter of the report relates to the objectives of these phases. The findings featured in this report are new data analysis in regard to evaluation questions regarding outcomes, impact and sustainability of Safewards. A summary of findings provided in previous reports is included as a chapter, in order to inform the integrated discussion and recommendations from the entire evaluation.

The Evaluation

The team

The independent evaluation of the Victorian Safewards Trial was conducted by the Centre for Psychiatric Nursing at the University of Melbourne, following a competitive tendering process. The evaluation team consisted of researchers with clinical and evaluation expertise, with support from consumer advisors. Throughout the project the evaluation team partnered with Safewards Leads and Consumer Consultants, who supported local access and data collection, and the team was also assisted in evaluation tasks by staff of the office of the Chief Mental Health Nurse.

Aim

The aim of the Victorian Safewards Trial evaluation overall was to explore the feasibility, acceptability, effectiveness and impact of Safewards for people in inpatient wards across the spectrum of acute adult, aged, youth and secure extended care inpatient mental health services in Victoria.

Scope of this report and earlier reports

This final report sums up findings from all phases of the Victorian Safewards Trial, but focuses in particular on outcomes in terms of: 1) seclusion events, 2) staff and consumer experiences of Safewards' acceptability and impact, and 3) the sustainability of Safewards across the participating Victorian inpatient wards.

The first report for the project was produced in **March 2015**. It identified trial preparations within organisations, providing preliminary data analysis of the Safewards pre-training survey and the Safewards readiness checklist. The second interim report, provided in **September 2015,** focussed on the process evaluation, with analysis of: staff knowledge, attitudes, and motivation regarding Safewards pre- and post- training; and fidelity with the Safewards interventions per-unit, over three time points in the intervention period.

This report focuses on the outcome evaluation, with detailed analysis of: seclusion events pre- and post- Safewards implementation, sustained fidelity with the Safewards interventions per-unit over a one year period, and quantitative and qualitative staff and consumer feedback about the experience, acceptability and sustainability of Safewards. The background and methods sections in this report provide detail relevant to evaluation of outcomes, impact and sustainability.

Evaluation research questions

This report addresses all the evaluation questions posed with reference to the program logic.

Training evaluation question:

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

Acceptability and applicability questions

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

Outcomes questions

- Was Safewards effective in reducing containment (seclusion events) of consumers in the Safewards Victorian trial wards?
- How did Safewards impact on staff and consumer experience of safety and conflict in participating wards?

Implementation and sustainability questions:

- How was Safewards implementation enabled and impeded?
- Did the participating wards achieve fidelity with the Safewards interventions, during beyond the trial phase?

Chapter 2 Methodology

The data for the Safewards evaluation were collected and analysed according to the three distinct parts of the trial. These were the Training, Trial and Sustainability phases. This methodology chapter provides detail about the evaluation design, the data sources, participants and data analysis techniques that were used to answer evaluation research questions, and the ethical approvals received for collection of data.

Evaluation of Safewards training

Design

To evaluate the Safewards training we employed a pre- and post- test design, utilising three surveys and diary. The researchers collaborated with staff from the Victorian DHHS to design the surveys and the Victorian DHHS administered the surveys and collated the data.

The Safewards training survey responses were captured via Survey Monkey for which a link was sent, by the Victorian DHHS, to staff of the seven health services involved in the trial. The Safewards Leads, one from each health service, were then asked to provide the survey link to staff within their service who would be taking part in the Victorian Safewards Trial. Paper surveys were also made available to all staff.

The online and paper survey formats provided information to participants that only aggregate data would be presented in reports to be completed by the evaluation team. Participants were asked to tick a box to indicate they understood the purpose of the survey, and submission of the survey indicated consent. Pre- and post- training survey responses were anonymous. Provision was made within the survey for staff to add a self-appointed unique identifier, so that pre- and post-surveys could be matched for analysis, while allowing participation to remain anonymous. The surveys are described briefly below and the timeline for survey completion can be seen in Table 2.1.

The **Safewards Pre-training Staff Survey** consisted of 21 quantitative and qualitative questions, designed to measure the level of staff knowledge of the 10 Safewards interventions, and staff confidence in implementing Safewards interventions. All staff were asked to complete the survey anonymously prior to undertaking training. This survey was administered between November 2014 and March 2015 (Appendix A).

The **Post-training Staff Survey** included 35 quantitative and qualitative questions, including the 21 questions identical to the pre-training staff survey, about the knowledge of staff related to the 10 Safewards interventions and their confidence in implementing these types of interventions. The added 14 questions sought feedback about the appropriateness and usefulness of the training materials. Staff were asked to complete this survey at the completion of all Safewards training. This survey was first administered in late February 2015, just prior to commencement of the trial. Safewards Leads were reminded of the post-training survey via email (9th of July) and it remained open until August 2015 (Appendix B).

The **Safewards train-the-trainer survey** was designed for completion only by the sub-group of staff who took part in the centrally-run, DHHS training workshops. This survey was designed to establish how closely the training delivered in each health service mirrored the training delivered in the train-the-trainer workshops. The survey includes 25 quantitative and qualitative questions. This survey was administered between March and June 2015 (Appendix C).

The Training and Implementation Diary was commenced by each participating organisation in this timeframe, reporting on the local training process. The Training and Implementation Diary was designed by the evaluation team for organisations to track the process of delivering training to staff and implementing the Safewards model and 10 interventions. The diaries were designed to record the enablers and barriers to training and implementation of the Safewards model and 10 interventions. An electronic file was sent to the Safewards Leads, which included a table of questions to be completed. These diaries were submitted to the Victorian DHHS, for inclusion in the evaluation. The Diary table is included in Appendix D.

Participants

We approximated the population for training surveys, i.e. the number of staff training participants = 540 (average 30 per 20 bed unit). Staff were asked to complete the same pre- and post- surveys, regardless of whether they participated in Safewards training at the train-the-trainer workshops or in local health service training. Only staff who attended central training ***also*** completed the Train-the-Trainer survey. The number of staff who attended central training over the 3 days was approximately 60.

Analysis

Data from the pre-and post- and the train-the-trainer surveys were analysed using SPSS. Demographic features of the participant sample were described. Pre- and post-training survey data was paired where possible. Statistical analyses included generation of descriptive statistics, and paired t-tests to assess the significance and magnitude of the change before and after training.

Evaluation of the Safewards implementation process

Design

Quantitative and qualitative data was collected over the course of the 12-week trial period. The primary purpose of these data was to evaluate the process of implementation and to routinely measure the degree to which interventions were being implemented at the beginning, middle and end of the trial. The following data was collected.

The **Readiness Checklist** is a preparation tool available as freeware on the UK Safewards website. It is a brief tool designed to assist staff to decide if the ward is ready to implement a given intervention. In the Victorian trial the Readiness Checklist was completed by each of the Safewards Leads and other ward staff and the data was supplied via the DHHS to the evaluators, for inclusion in the evaluation.

The Readiness Checklist included three scales, *training, champions* and *preparation* for interventions, each scored out of 10. For each intervention there were between one and eight questions related to *preparation*, including: identifying processes, printing posters, purchasing materials, and distributing information to staff. To obtain a scale score for interventions, first a score was obtained for each intervention. Next, if all of the questions received a 'yes' for the intervention of interest, then overall that intervention was considered to be prepared for that scale and was allocated '1'. If not all of the preparations were complete, that intervention was allocated '0'. The readiness checklist is provided in Appendix E.

The **Fidelity Checklist** is an observational evaluation tool available as freeware on the UK Safewards website. It is a brief standardised audit tool used by the UK Safewards trial team and available for auditing in Victoria. This tool was modified and used to collect data about the consistency with which each of the 10 interventions were and were not implemented in each ward. The checklist enabled scoring of overall fidelity with intervention implementation, per site for the intervention period. Additionally, the checklist invited qualitative data in the form of comments to supplement ratings. The modified Fidelity Checklist is included as Appendix F.

Five **focus groups** were conducted with staff from four health services. One focus group was conducted for each service type, that is adult, adolescent and youth, aged, and secure extended care units. In addition, consumer consultants were invited to participate in a separate focus group. The Safewards lead at each of the four services forwarded an invitation to ward staff with information about the focus groups. Interested staff then contacted the evaluators, who provided the Plain language statement and consent form to prospective participants. The 90 minute focus groups were conducted at participating health services by two members of the evaluation team. The focus groups were recorded and transcribed verbatim.

A semi structured interview schedule for the focus groups aimed to elicit rich accounts from staff about their experiences of implementation and practice, using Safewards. Topics in the focus group interview schedule included:

the effectiveness of the training program; supporting materials; and champion roles. Barriers and enablers of implementing the model in the Victorian context were explored. Participants were invited to discuss how the model was integrated by the service and the sustainability of the model in the service. An interview guide is provided in Appendix G.

The Training and Implementation Diary earlier described (on p 13) was completed as part of the evaluation of the Safewards implementation process. The 7 diaries were submitted to the Victorian DHHS between May and July 2015, after the Safewards trial phase.

Participants

The **training and implementation diaries**, **readiness checklist** and the **fidelity checklist,** all provide data per ward. Diaries and readiness checklists were submitted by all Safewards Leads, representing all 18 wards involved in the trial. The fidelity checklist was administered by an evaluator during a walkthrough of each ward at the start and end of the trial, thus there are 36 fidelity checklists available. In addition, some Safewards Leads arranged a midpoint fidelity checklist to be complete locally which provided additional data for 14 wards.

For each of the focus groups, the goal was to recruit up to 10 participants. However the potential recruitment pool varied for the 5 groups. Working on the average of 30 staff per ward, the following number of staff received an invitation to participate from the four health services: Adult 150, Adolescent/youth 90, Aged 90 and SECU 60. An email was provided to Safewards leads at every service, inviting consumer consultants and peer workers from all involved services to a focus group held at a university setting. The pool of consumers consultants was more limited, as not all inpatient facilities has a consumer consultant involved in that setting, therefore we estimate the pool was 10 consumer consultants.

Analysis

For the purposes of drawing conclusions regarding the **Readiness checklist**, equal weight was given to each of the three scales. Three general levels of readiness emerged from the data, which we labelled 'well prepared', 'somewhat prepared' and 'under prepared'.

The **Fidelity Checklist** data was analysed using a process to match fidelity analysis in the UK Safewards experimental trial (Bowers *et al* 2015). That is, each intervention was recorded as either being present or not, and for some interventions the evaluators were required to count the number of occurrences; for example evaluators counted discharge messages, up to 10. Each intervention then received a score out of a maximum ten. For *soft words* intervention, the presence of a poster would result in a 10/10 but poster absence would result in 0/10, whereas for *discharge messages* intervention the score was a composite of the presence of a display and then number of messages displayed, so the score ranged from 0-10. The result is a score out of 100. The fidelity scores were collated and analysed using SPSS. Average fidelity scores were compared across wards, service types and for each intervention.

Focus Group data were inductively analysed for themes, related to experiences of Safewards implementation, understandings of the model and participant experiences of applying Safewards interventions in their everyday work. The thematic map for each focus group was then compared with themes from earlier focus groups, to build a thematic picture of overall staff experience of implementation processes and use of Safewards (Braun & Clarke, 2006).

The Consumer Consultant/worker focus group data was analysed and reported separately from the data generated in the other staff focus groups, because overall consumer workers were not directly involved in implementing Safewards or using the intervention themselves. The rich contribution of consumer workers was mainly aligned to their perceptions of consumers' experiences of the model and the interventions, gained from observation and feedback from inpatient consumers.

Evaluation of sustainability

Design

The final stage of the evaluation had three primary aims. The first was to continue to measure fidelity over a further 9 months, the second was to understand the staff and consumer perspective of being involved in Safewards in Victoria, and the third was to establish if Safewards had an impact on seclusion rates in the trial wards. Seclusion as an outcome was to be evaluated by comparing rates pre- and post- the implementation, as well as to assess if there were differences between trial and non-trial sites.

Two surveys, one for ward staff and the other for consumers, were developed by the evaluation team and they are detailed below. Survey Monkey was again used to host the surveys and evaluators sent the electronic survey link to Safewards Leads who then provided it to staff, along with the Information and consent form.

Consumer consultants and peer workers from all involved services were invited to the focus group held at a university setting. Consumer feedback surveys were offered to consumers in 5 of the 7 participating AMHSs, where ethical approval had been granted to do so and where consumer staff or education staff were able to administer the surveys.

The **Consumer Post Implementation Survey** was a 26 question survey, designed in part with questions that were directly comparable to the staff survey. The questions were both quantitative and qualitative regarding the acceptability, applicability and impact of the Safewards model and 10 interventions to consumers. In addition demographic information was sought. The survey was administered in each ward either by the consumer consultant or a nurse educator, between February 2016 – April 2016. The survey was hosted on survey monkey and consumers could choose to complete the survey themselves or with the support of the consumer consultant. Paper versions of surveys were also supplied (Appendix H).

The **Safewards Post Implementation Staff** survey was a 49 question survey developed by the evaluators. The questions were both quantitative and qualitative regarding the acceptability, applicability and impact of the Safewards model and 10 interventions to staff in practice. In addition demographic and professional information was sought. This survey was administered via a survey monkey link supplied to ward staff via the Safewards Lead at each health service. And paper versions were also made available to staff. The surveys were completed between December 2015 – April 2016 (Appendix I).

The feedback surveys were delayed for two reasons: 1) the post training surveys remained open til August 2015 in order to maximise response rates; and 2) the evaluators were awaiting organisational governance agreements as required, following the multisite human research and ethics (HREC) approval that was granted in July 2015. Institution-based HREC finalisation was vital to gather and report on consumer feedback.

The **Client Management Interface (CMI)** data represents all standardised records of mental health service contacts that are reported to the Victorian Government, under existing service agreements. The evaluators were provided with de-identified per admission data, regarding all mental health inpatient consumers in Victoria. Linked data was provided about seclusion events, and also the numbers of available beds. This data enabled generation of per ward seclusion rates, standardised to allow for variations in ward size and occupancy.

Participants

Five health services agreed to continue through this stage of evaluation, beyond the trial period. The participating services included 13 wards. Based on the presence and availability of a consumer worker or educator to assist in surveys, current consumers were approach on eight of these wards from three health services, and invited to take part in the consumer survey. Approaches to consumers in these sites were enabled by site-level ethics approvals. Staff from 13 wards were invited to participate in the staff survey, providing a pool of 390 potential staff survey respondents.

The fidelity checklist was completed at the start of this phase in all 18 wards (June 2015), however one service did not grant access for the final ward walk through, so fidelity data is analysed at the final endpoint (April 2016) for 14 of the total 18 wards. Eight wards also chose to conduct their own fidelity walk through at the midpoint of this phase (November 2015).

Analysis

The fidelity scores were collated and analysed using SPSS. Average fidelity scores were compared across wards, service types and for each intervention, the same as for the trial phase.

Quantitative data from the Consumer and Staff survey was analysed using SPSS. Demographic features of the participant sample were described. Descriptive analysis of data was completed. Qualitative data were analysed using a thematic approach. The higher order themes were developed a priori based on the questions in the survey, and emerging themes were developed inductively from the data during analysis.

Stata 14 was used to perform the analysis of the CMI data. The 18 trial wards were identified and then non trial wards that matched the service type of the trial wards were grouped according to the four services types in the trial. The number of operational beds available for each ward by month was established, this was then utilised to calculate the number of seclusion events per 1000 occupied bed days per ward per month. These data were then grouped into three time points, pre-trial (1 Dec 2014 – 28 Feb 2015), post-trial (1 Jun – 31 Aug 2015), and follow-up (1 Dec 2015 – 29 Feb 2016). T-test analysis was conducted to assess differences between seclusion rate between pre and post Safewards and pre and follow-up, both within Safewards trial wards and between trial wards and non-trial wards.

Ethical approvals

The training surveys, checklists, organisational diaries and CMI data were conceived of as part of the contracted quality improvement work between the Department of Health and Human Services and the service sites, therefore the ethical issues associated with collection of this data was reviewed by the University of Melbourne HREC. The collection of consumer and staff feedback surveys and focus groups interviews required ethical review at the organisational level, there for the ethical issues associated with collection of these data were reviewed as a low risk application by Monash Health HREC, as a multisite application. Local co-investigators and research governance arrangements were negotiated with each participating organisation. For ethics approval see Appendix J.

Table 2.1 below illustrates the components of the evaluation and the timing for each point of data collection.

Table 2.1 Trial activities and evaluation data collection timing

		2014	2015											2016			
		Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
	Activity																	
Safewards Victorian Trial	Central train-the-trainer	Session 1 & 2	Session 3															
	Local training & implementation																	
	Trial																	
	Follow-up																	
	Data Sources																	
Training evaluation	Pre training survey																	
	Post training survey																	
	TtT Surveys																	
	T & I diary																	
Process evaluation	Readiness checklist																	
	Fidelity checklist				1	2	3											
	Focus groups																	
Outcome evaluation	Fidelity checklist												4		5		6	
	CMI data																	
	Staff Survey																	
	Consumer survey																	

Chapter 3 Results: Summary of results from previous reports

This chapter provides a summary of results that have been presented in detail in other evaluation reports. It includes the evaluation of readiness for implementing Safewards on each ward, the three training surveys and the training and implementation diary.

Readiness checklist

The Safewards readiness checklist, a simple resource provided on Safewards.net for implementing organisations to use, was completed for all 18 wards participating in the trial. This data was downloaded on the 11th of March 2015. The readiness checklist is scored across three scales out of ten, *training, champions* and *preparation* for interventions. For each intervention there were between one and eight questions related to *preparation*, including such things as: identifying processes, printing posters, purchasing materials, and distributing information to staff. Therefore to obtain a scale score for interventions, first a score was obtained for each intervention. Next, if all of the questions received a 'yes' for the intervention of interest, then overall that intervention was considered to be prepared for that scale and was allocated a '1'. If not all of the preparations were complete, that intervention was allocated a '0'. For the purposes of drawing conclusions regarding the Readiness checklist, equal weight has been given to each of the three scales. Three general levels of readiness emerged from the data, which we labelled *well prepared, somewhat prepared* and *under prepared*.

Well Prepared: Those wards that had reportedly completed training for seven to ten of the Safewards interventions and had Champions identified for at least 7 of the Safewards interventions. In addition they had also completed preparatory work to implement the at least 7 interventions. Five wards fell into this category.

Somewhat Prepared: Wards that report being prepared very well in some areas and not so well in others. For example they had either completed most training but had not identified many Champions, and had additional preparatory work to undertake for between three- six interventions. Otherwise this involved wards that had not completed training but had identified between seven to ten Champions and had completed almost all preparation for all of the interventions. Ten wards fell into this category.

Under Prepared: Those wards that scored a '0' for one scale and still require significant preparation on at least one other scale even if one scale is well prepared. Three wards fall into this category.

Training surveys

The results from the three online pre- and post- training surveys that were distributed to all Safewards training participants at a train-the-trainer workshop and/or health service training sessions are summarised below. In addition, attendees of the train-the-trainer workshops also had the opportunity to complete the train-the-trainer survey after all three train-the-trainer workshops had been completed.

Two evaluation questions were answered with this data:

> Question 1. How effective was the Victorian Safewards training program in building participants knowledge and confidence in using the Safewards model and 10 interventions?
>
> Question 2. How was training and implementation conducted in the participating services?

Data from the Safewards pre and post training surveys was downloaded on the 31st of August 2015. The data were analysed to report frequencies and descriptive statistics.

It was anticipated that a potential pool of 400-450 staff would be trained in the Safewards model and 10 interventions. The final number of respondents of the surveys included 414 for the pre training survey and 171 for the post training survey. Within these groups 90 respondents provided a unique identifier that allowed their data to

be matched across both the pre and the post training surveys. Each table included here indicates the number of missing responses for each question reported.

Demographics of survey respondents

The majority of participants were female, speak English as their main language at home and do not identify as being Aboriginal or Torres Strait Islander. This pattern is consistent for both the pre and post surveys and within the matched group.

All health services participating in the Victorian Safewards Trial are represented to a variable extent in all surveys. Staff from Melbourne Health wards are very highly represented in the post-training survey and in the matched pairs sub group. Most respondents indicated they were a registered nurse but a significant number of respondents reported their role as 'other'. This category included allied health professionals, non-clinical staff and other medical professionals. In the majority of cases respondents were not in the role of RRI or Safewards Leads. The number of respondents indicating they were in the role of Champions more than doubled between the pre- and post- training surveys.

Pre and post training comparative data analysis

When completing the pre- and post- training survey, respondents were asked: their level of knowledge regarding the Safewards model and the 10 interventions; their confidence in applying the Safewards model and the 10 interventions; and their motivation to apply the Safewards model and the 10 interventions. Ratings were made on a 5-point likert scale where 1= none, 2 = Fair, 3 = Good, 4 = Very Good, and 5 = Excellent. Table 6 provides the average of the respondents' answers for the Safewards model and 10 interventions for each of the questions.

Respondents' answers to these questions ranged across responses from 'none' to 'excellent' for the model and the 10 interventions. Table 3.1 highlights the average pre- and post- response for each of the model and 10 interventions regarding knowledge, confidence and motivation, as well as the change between the pre- and post-survey. Prior to training on average respondents reported knowledge and confidence regarding Safewards was generally between 'fair' and 'good'. This had improved in the post training survey to between 'good' and 'very good'. Staff motivation to incorporate the model and 10 interventions into their work on average was initially good to very good and consolidated as 'very good'.

Table 3.1 Self-reported average level of Safewards knowledge, confidence and motivation pre and post training

	Pre (n = 411)		Post (n= 170)		change
Knowledge	Mean	SD	Mean	SD	score
Safewards model	2.04	0.88	3.45	0.93	1.41
Clear mutual expectations	2.19	1.00	3.62	0.91	1.43
Soft words	2.37	1.09	3.69	0.92	1.32
Talk down	2.32	1.10	3.65	0.85	1.33
Positive words	2.55	1.13	3.78	0.95	1.23
Bad news mitigation	2.01	1.00	3.48	0.92	1.47
Know each other	2.33	1.12	3.76	0.95	1.43
Mutual help meeting	2.12	1.07	3.65	1.01	1.53
Calm down methods	2.40	1.12	3.75	0.94	1.35
Reassurance	2.44	1.14	3.74	0.95	1.30
Discharge messages	2.23	1.13	3.74	0.99	1.51
Confidence	Pre (n = 411)		Post (n= 169)		
Safewards model	2.13	1.04	3.40	0.90	1.28
Clear mutual expectations	2.25	1.07	3.49	0.91	1.24
Soft words	2.41	1.13	3.65	0.93	1.24
Talk down	2.34	1.11	3.55	0.87	1.21
Positive words	2.51	1.17	3.69	0.90	1.18
Bad news mitigation	2.11	1.05	3.39	0.93	1.28
Know each other	2.36	1.17	3.66	0.97	1.30
Mutual help meeting	2.19	1.10	3.57	0.99	1.37
Calm down methods	2.41	1.14	3.63	0.87	1.22
Reassurance	2.43	1.16	3.63	0.92	1.19
Discharge messages	2.28	1.15	3.67	0.96	1.38
Motivation	Pre (n = 411)		Post (n= 167)		
Safewards model	3.24	1.19	3.93	0.92	0.69
Clear mutual expectations	3.26	1.18	3.89	0.93	0.64
Soft words	3.30	1.19	3.98	0.92	0.67
Talk down	3.29	1.17	3.96	0.88	0.66
Positive words	3.36	1.17	4.06	0.91	0.70
Bad news mitigation	3.18	1.20	3.83	0.95	0.65
Know each other	3.27	1.19	3.84	1.00	0.57
Mutual help meeting	3.24	1.20	3.89	0.94	0.65
Calm down methods	3.31	1.17	4.04	0.91	0.74
Reassurance	3.34	1.18	4.03	0.92	0.69
Discharge messages	3.23	1.19	3.87	1.00	0.64

The results of 90 participants who provided matched data were then analysed to assess the significance and magnitude of the change before and after training. As there was little variation between the interventions for each of the key domains of knowledge, confidence and motivation, the scores for each were tallied to gain an overall score for each domain out of 55. Table 3.2 shows the paired samples t-test result for each domain indicating there was a significant improvement between pre- and post- training scores, for knowledge, confidence and motivation. The magnitude of change as measured by Cohen's *d* is large for knowledge and confidence and moderate for motivation.

Table 3.2 Analysis of difference between pre and post self-reports of Safewards Knowledge, Confidence, and Motivation using matched pairs

	Paired difference						
	Mean	Std. Deviation	95% confidence interval	t	df	Sig. (2-tailed)	effect size cohen's *d*
Total Knowledge	15.78	12.58	13.12- 18.45	11.77	87	.000	1.25
Total Confidence	13.87	13.84	10.92- 16.82	9.35	86	.000	1.00
Total Motivation	7.44	13.70	4.51 – 10.38	5.04	85	.000	0.54

Post training data analysis

Respondents of the post- training survey were asked to indicate the frequency with which they could envisage using the Safewards model and 10 interventions in their work place. Their ratings were made on a 5-point likert scale where 1= never, 2 = rarely, 3 = sometimes, 4 = usually, and 5 = always. The average of the respondents' answers indicates that for all interventions and the Safewards model respondents reported they would 'usually' use them.

Approximately 85% of participants reported they participated in training at their health service. Eighty-seven percent of respondents attended between one and five events. The structure of the training delivered was reported by half the participants as 'short in-service' and 'interactive workshop'; respondents were able to provide as many responses as appropriate. The length of training varied, from 42% of respondents who reported attending a whole day event and another 40 % who reported attending events that were 1 hour or less. Of the 35% of respondents who reported attending only one training event 67% of these reported attending a whole-day training event and 23% reported attending training that was one hour or less.

The participants were asked to rate a variety of aspects of the training on a 5-point likert scale where 1= none, 2 = Fair, 3 = Good, 4 = Very Good, and 5 = Excellent. The average of the respondents' answers for the components of the training contrasted respondents who reported they attended the train-the-trainer workshops, health service training, or both. Generally participants who attended the train-the-trainer workshops rated most aspects of the training as 'very good'. The respondents who attended health service training rated the various aspects of training 'good' to 'very good'. These results were equivalent for those who participated in both the train-the-trainer workshops and health service training. All components of training were rated well and the train-the-trainer sessions were rated more highly than the local training on all elements. The video materials and time for planning were lowest rated by training participants. Clarity of the trainers and questions answered by the trainers about the interventions were the most highly rated elements of the training.

Train-the-trainer data analysis

The 'train the trainer' survey was designed to capture information about the extent to which activities from the train-the-trainer workshops were utilised in local health service training sessions. The survey results are summarised below.

The train-the-trainer survey was completed by 29 respondents, half of whom were female. All respondents reported speaking English and none identified as Aboriginal or Torres Strait Islander. Each of the participating health services were represented and approximately 40% of respondents were in the role of Safewards or RRI lead or both. Most of the respondents were nurse unit managers. Those who answered that they belonged to another professional role(17%) were occupational therapists and an allied workforce development officer. Fifty-five percent reported attending all three train-the-trainer workshops, a further 24% attended two of the workshops and 7% attended one workshop. Eighty-three percent reported having responsibility for training other staff in their health service.

A list of workshop activities was provided for each day of the workshops and respondents were asked to rate their own experience of the activity on a five point likert scale (1=poor, 2= fair, 3= good, 4=very good, 5= excellent) and there was a 'not applicable' option for those who did not attend all three workshops. In addition, training participants were asked to report if the activity would be utilised in local health service training. Ratings of the each of the activities ranged on average from the lowest at 1.8 for *mutual help meeting* activity, to the highest at 4.1 for the activities regarding *know each other*. Expected use of the activities as reported in the survey ranged from 1 respondent anticipating using the *clear mutual expectations* activity to 13 respondents expecting to utilise the *know each other* activity.

Thirteen respondents provided qualitative feedback, which was mostly positive, although one respondent felt that it was not a true train-the-trainer package and would require significant work to "make it appropriate" for their health service. Positive comments were focused on the high quality of the trainers, great examples for practice and good structure.

This survey also provided the opportunity for respondents to offer some detail about the training they delivered at their local health service. It was reported that local health services did not deliver training in the same timeframe or format as the train-the-trainer workshops. To maximise staff participation in Safewards training, some services collapsed all of the content into one full day of training, and thus could not include many activities. One respondent reported that their approach to training was to link each intervention back to the Safewards model, and suggested that they did this more methodically than what was done in the train-the-trainer workshops. The training at health services gave more focus and time to planning the implementation of each intervention.

Overall, the three surveys elaborate the extent of training engagement, the diverse content delivered and the substantial gains made, via the training component of implementation.

Training & implementation diaries analysis

Diaries were completed for all seven health services, representing all 18 wards involved in the Safewards trial and these were provided for evaluation. The data analysis is presented below, grouped by the four higher order themes: 1) factors that assisted training; 2) barriers to training; 3) factors that assisted implementation; and 4) barriers to implementation. The diaries were completed with comments specific to each intervention. The process of analysis revealed themes emerging under each of the higher order themes. The feedback about the interventions grouped consistently within the emerging themes.

Factors that assisted training

Delivery of training in health services was supported in a multitude of ways that are discussed in the following section. Five key supports included: participation in previous training with related content; supportive processes in place for using training materials and other operational supports; champion involvement; staff acceptance of and identification with the Safewards model and 10 interventions; and cross disciplinary collaboration.

Previous training

Education and training about different but related topics has reportedly been helpful to staff receiving Safewards training. Specifically the prior knowledge has assisted staff understanding of Safewards and has also provided experiences of successfully translating new knowledge into practice.

Support Processes

In the diaries a number of processes were reported to facilitate training. Some relate to the training materials and information from the UK trial which are freely available on the Safewards website and which were provided during the train-the-trainer sessions. In addition, discussion of UK trial experiences, the fidelity statements about each intervention, and the information handouts were helpful. The powerpoint slides developed for Victoria were also highlighted as very useful.

Two key delivery modes of training were identified and both were reportedly successful, in terms of staff participating and engaging with the material, in the service in which they were delivered. These were one day training covering the Safewards model and 10 interventions; the other method was 45-minute workshops where two interventions were discussed at a time.

Champions

Engaged and enthusiastic champions who were in place prior to the training commencing were considered an asset. In addition to champions being appointed early, when champions were respected by staff and had a skill set complimentary to the intervention, this also had a positive impact on training and implementation.

Staff accepting and identifying with Safewards intentions

Training for many of the interventions was well received, when staff accepted that the intention of the intervention was worthwhile, and when they could identify with the purpose. This occurred when staff either reflected on skills they already used, or realised that they could work differently to prevent flashpoints.

Cross disciplinary collaboration

Involving staff from other disciplines as trainers was reported to be beneficial. For example, an Art therapist was available and this had a positive impact on staff understanding of the *discharge messages* intervention. In some sites an occupational therapist was involved in calm down methods training.

Factors that assisted implementation

Engagement

This theme refers to engagement of personnel in the project at all levels of the health service, from executives, to ward managers, to staff of all disciplines, and also consumers. Various mechanisms of engagement were described in the diaries as supporting the implementation of interventions. For example, the *know each other* intervention was pre-empted in the train-the-trainer workshops as one that may meet with resistance from staff. As detailed in one diary, it was important to engage with nursing staff about this intervention to find common ground among team members, to ensure that the intervention was implemented. Using *know each other* as an example, one ward engaged the management team to complete their own *know each other* profiles, prior to training the staff about this intervention.

Having champions and allied health staff engaged with the model and interventions was reported to be vital to successful implementation, as was the engagement of consumers in interventions such as discharge messages.

Existing and new organisational processes

Existing processes were discussed in a number of diaries as assisting with the implementation of many interventions. For example wards that had an existing consumer meeting of some kind commented that the agenda and focus of the meetings was easily changed to accommodate the *mutual help meeting*.

The introduction of the Safewards model and 10 interventions has provided the impetus for introducing new processes to ensure interventions are implemented as intended. An example of this is the *positive words* intervention which was supported, in one ward, by a new process, using the handover checklist, and was also seen to support the introduction of bedside handovers.

Barriers to training and implementation

The Safewards training and implementation was impacted by various barriers. These barriers posed more of an issue in some wards than others. Even within health services there was some substantial variation in the way training was supported and received per ward. Barriers included: an attitude of resistance; issues with training materials; the fit of Safewards language; and operational procedures.

Resistance

General resistance to Safewards was reported in a number of forms, lack of acceptance of change, staff feeling overworked, and ward managers not releasing staff for training. In addition, there were a number of interventions for which staff held the belief "*we already do this*". This attitude then impacted on the way they viewed some interventions, for example *reassurance, positive words, and bad news mitigation.*

Training materials

The views about the training materials provided for local training were polarised, as expressed in the feedback. Some respondents felt very positive about the materials from the UK and the train-the-trainer workshops. However, the diaries provided information about what was lacking from the training materials from the UK, as well as in the local train-the-trainer package. Some respondents felt that the inclusion of good case scenarios to illustrate each intervention would support the training better.

Language

The use of language in the Safewards model and 10 interventions was mentioned as a barrier to training in two ways. The first is the perceived lack a recovery orientation, for example "*The language used at times in the examples provided through Safewards resources were perceived as not being recovery oriented"*. Second, for specific interventions staff reported that the language which was presumably culturally acceptable for UK settings, was not acceptable in Australian expression, for example "*Some of the Soft word examples provided were considered patronizing"*.

The training and implementation diaries add great depth to understanding of the processes involved in delivering Safewards training in local health services and implementing the Safewards model and 10 interventions.

Chapter 4 Results: Implementation fidelity

This chapter reports the results of the fidelity checks conducted at each health service (n=18) at least twice during the three-month trial period, during the 3rd and 4th week (March 2015) and then between the 13th and 15th week (May 2015). During the sustainability phase the research team conducted two site visits (18 and then 14 visits), the first 6 months after the completion of the trial phase and the second 3 months later, which was 12 months after the first site visit in the trial phase. The main purpose of the site visit was to meet with staff and complete the Safewards fidelity checklist. Some health services also conducted a mid-point fidelity checklist themselves, during both the trial and sustainability phases and submitted the checklist data for inclusion. One health service withdrew from the sustainability phase of the evaluation, resulting in one less adolescent/youth unit and three less adult units.

Fidelity scores

Table 4.1 indicates the overall fidelity scores over time for all wards involved in the trial. The data shows that at the first time point, wards were delivering on average 5 interventions (represented by a mean of 50.7) and by the final time point of the trial phase wards were delivering on average 7 interventions (represented by a mean of 68.5). Improvements in fidelity continued throughout the sustainability phase. Improvement was seen from the end of the trial to time 4 when wards were delivering 8 interventions on average and by the final time point wards were delivering on average 9 out of 10 interventions. It is noteworthy that 4 wards withdrew from participating in the final fidelity check.

Table 4.1 Overall fidelity scores over time

	Time point	N	Minimum	Maximum	Mean	Std. Deviation
Trial Phase	**Time 1**	18	0	85.5	50.7	25.9
	Time 2	14	1	98.0	60.5	30.1
	Time 3	18	30	99.0	68.5	22.0
Sustainability Phase	**Time 4**	18	45	100.0	80.3	17.1
	Time 5	8	55	97.5	78.6	17.0
	Time 6	14	55	100.0	90.4	10.9

Figure 4.1 highlights the trajectory of improvement of each service type for both the trial and sustainability phases of the evaluation, each 10-point range indicates that one intervention is being implemented, so for example a score of 45 indicates that at least four interventions are being implemented. Adult services showed consistent improvement over the six time points. At the initial fidelity check on average these services were delivering four interventions. By the end of the trial phase they were delivering six interventions. Adult services continued to implement further interventions throughout the sustainability phase to end with an average of nine interventions being delivered 12-months after the start of the trial. In contrast the Adolescent /youth services began the trial with high fidelity; seven interventions at time 1. For the remaining fidelity visits the scores varied between seven and nine, consolidating with nine interventions 12-months after the trial began. The Aged services displayed a different pattern. The fidelity scores began at 5 interventions at the first time point and had made a slight gain by the end of the 12-week trial period. However, the greatest gains for the Aged services were seen in the sustainability phase, where fidelity was at 8 and 9 interventions for the first and final fidelity visit, respectively. The SECU's involved in the trial made the most substantial gains, in the trial period, starting lower than all other services at the first time point (delivering 4 interventions), then achieving the highest fidelity score (8 interventions) of all service types by the third time point.

Whereas during the sustainability phase the SECU's continued to deliver around 8 interventions, the fidelity score for time five is for only one of the two SECU's involved.

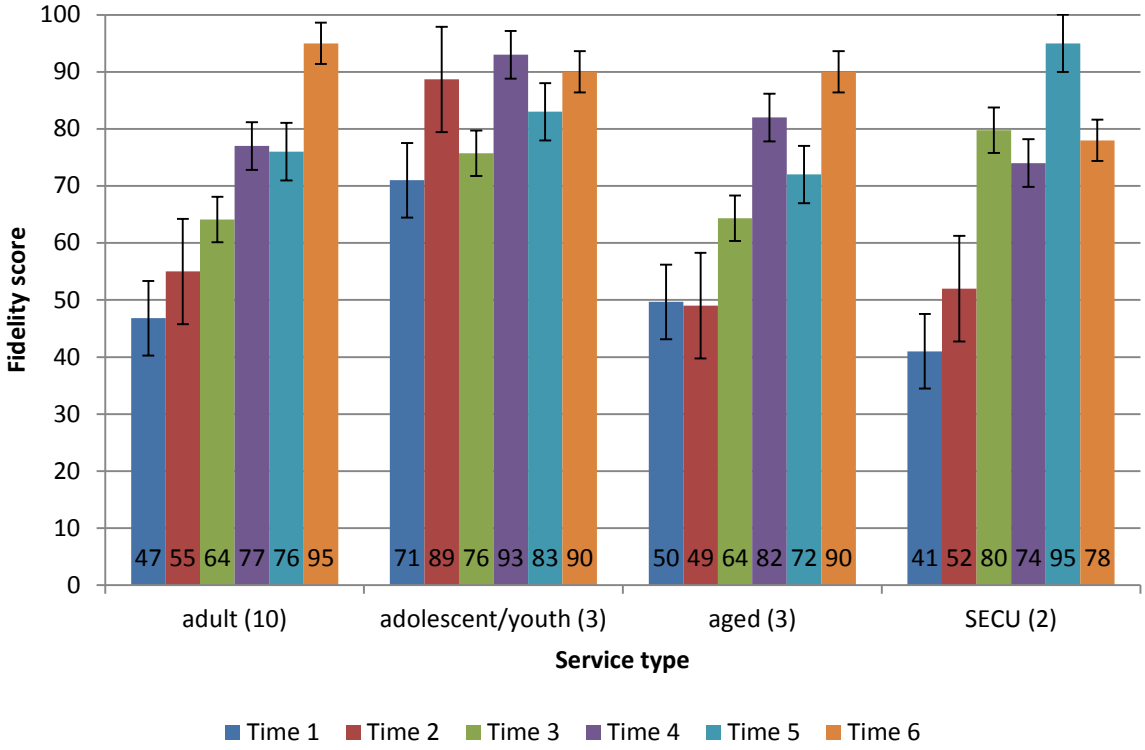


Figure 4.1 Fidelity scores by service type over time

Figures 4.2 and 4.3 highlight the fidelity scores for each of the de-identified individual wards over time. The adults wards are displayed together in figure 4.2 and all other wards are grouped in figure 4.3. These figures provide a picture of the degree of variability between the wards involved in the trial. Each de-identified ward is represented by one bar and each colour represents a time point when the fidelity was measured, the number inside the each colour segment is the fidelity score for that time-point. Figure 4.2 shows that there was considerable variability across the 10 adult services and within some of the wards. Some wards started the trial with high fidelity scores but decreased by the end of the trial phase, and then made substantial gains by the end of the sustainability period (Wards 2 and 3). In contrast ward 10 began the trial delivering 8 interventions and at the end of the sustainability phase was delivering at least 9 interventions, this ward only varied slightly between 7 -9 interventions across all six fidelity checks. Other wards started from a low or very low score at time one and made steady gains to be delivering at least nine interventions by the end of the sustainability phase (wards 1 and 9). The remaining four wards made steady gains however three of these did not participate in fidelity checks past time 4. The seven adult wards who participated in the final fidelity check were all delivering 9 out of 10 interventions at the end of the sustainability phase.

In contrast, the fidelity scores over time indicated less variability across the wards in the adolescent/ youth, aged and SECU services. All wards were implementing some Safewards interventions at the time of the first time point, and all but one ward had made gains in the number of interventions they were implementing by the third time point. Ward eight maintained the number of interventions they were delivering at around 4 interventions for the duration of the trial, but increased the number of interventions being delivered consistently throughout the sustainability phase with a final score of 8 interventions. Ward three made the most sizeable gains improving from the delivery of 2 interventions at the first time point, to 7 interventions at the third time point, however decreased throughout the sustainability phase. Seven of the eight wards continued to be involved to the end of the sustainability phase and all but one of these was delivering between 8 and 10 interventions.

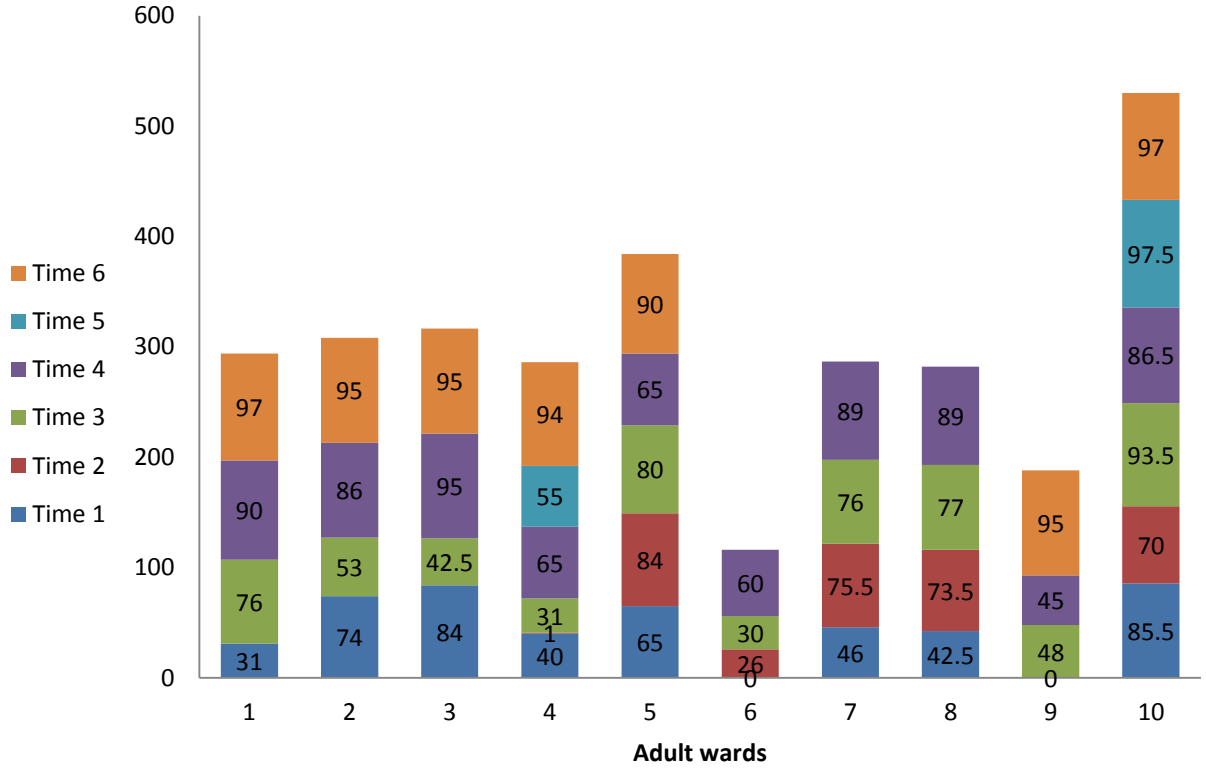


Figure 4.2 Fidelity scores over time of individual adult wards

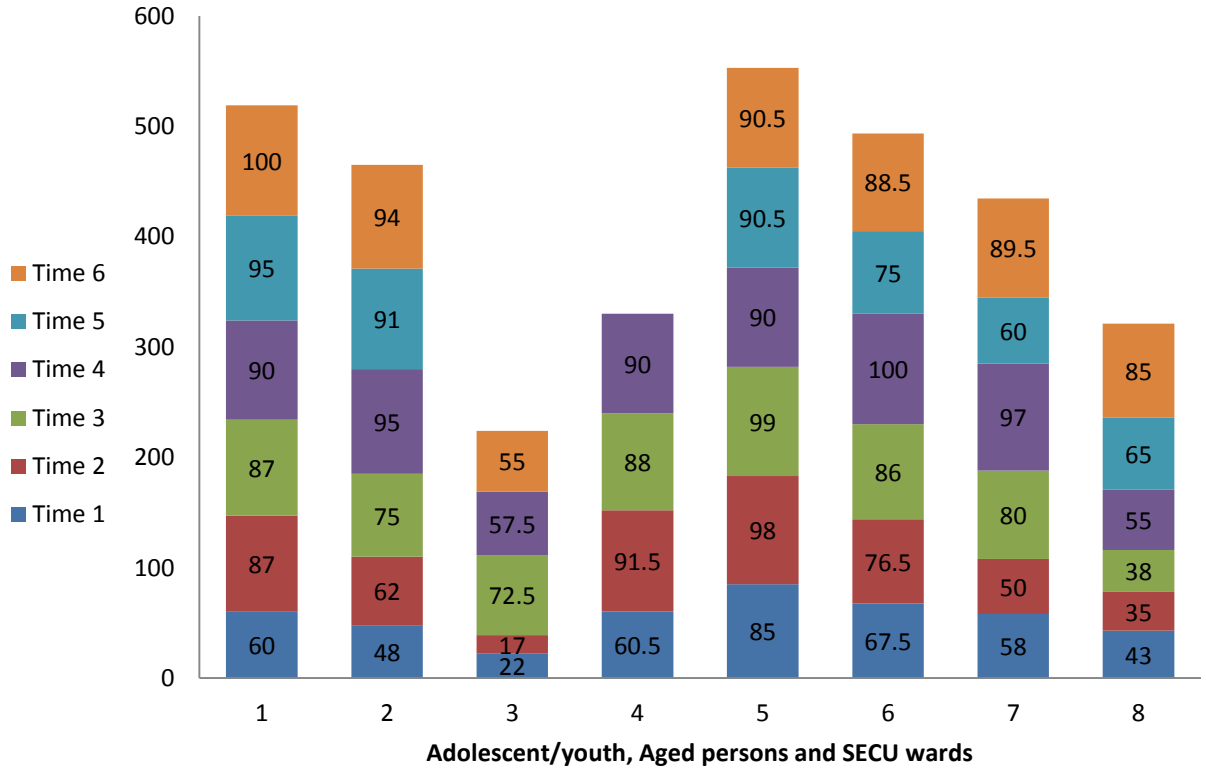
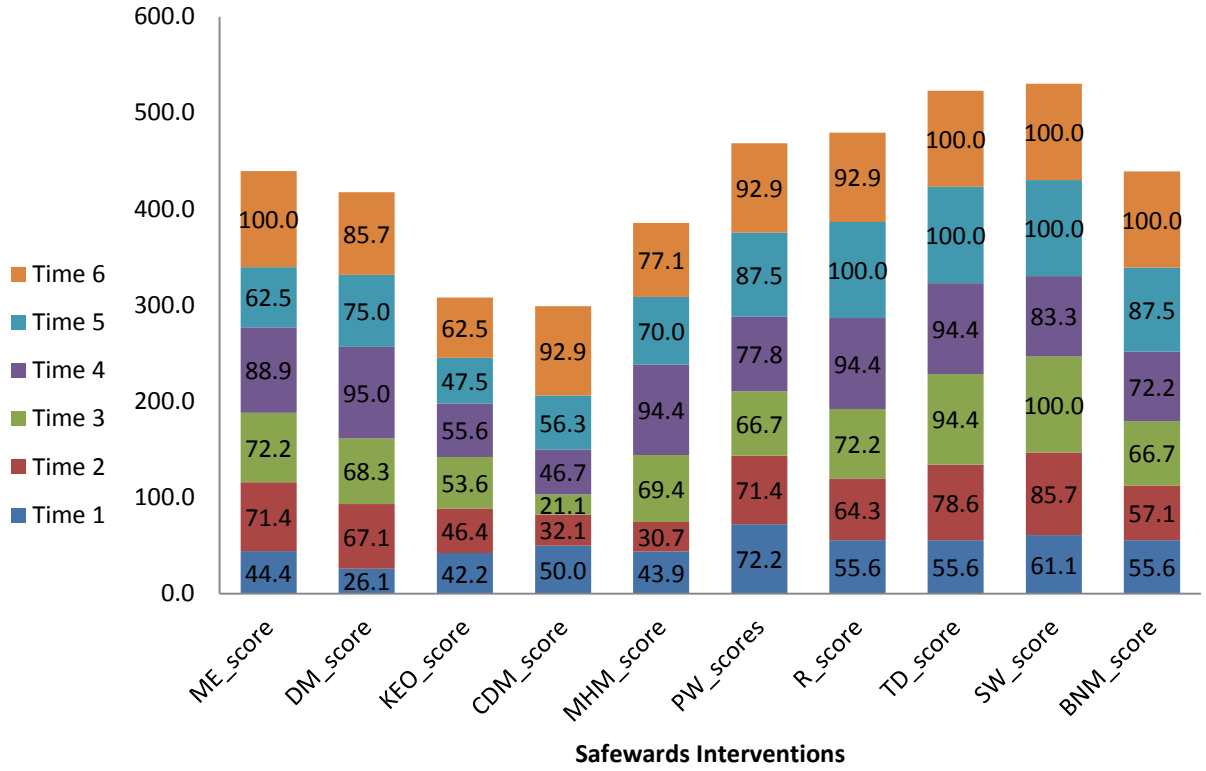


Figure 4.3 Individual ward fidelity scores over time of SECU, Aged and Adolescent/youth services

Figure 4.4 displays the fidelity with which each of the 10 interventions was being delivered over time, on average across wards. The figure indicates that *soft words, talk down, reassurance*, and *bad news mitigation* were the most consistently implemented interventions for the duration of the trial and sustainability phases. The use of *calm down*

methods decreased in the trial phase but then increased substantially throughout the sustainability phase. Use of *know each other* and *positive words* on average did not change substantially over the course of the trial, but were delivered slightly more as the sustainability phase continued. *Mutual expectations, discharge messages* and *mutual help meetings* on average were implemented with greater frequency as the trial continued and even further throughout the sustainability phase. Some caution must be taken in interpreting the higher rates of fidelity for interventions such as *soft words* and *reassurance*, as the threshold for positive recording is lower than is the case for other interventions.



Note. The abbreviations for the interventions mean the following; ME mutual expectations, DM discharge messages, KEO know each other, CDM calm down methods, MHM mutual help meeting, PW positive words, R reassurance, TD talk down, SW soft words, and BNM bad news mitigation.

Figure 4.4 Fidelity score by intervention for all wards over time

The fidelity checklists overall show a process of increasing implementation over time. There were notable variations, between wards and service types, in terms of early uptake. Variations were also evident in the rate of practice change over the trial period and variable uptake continued throughout the sustainability phase.

Chapter 5 Results: Seclusion rates

This chapter presents CMI data for mental health inpatient units involved in the Safewards trial and all other mental health inpatient units in Victoria. Analysis was conducted using Stata 13. The data were analysed according to the trial phases and these were defined in 3 month blocks, thus four time points have been defined, which are: pre-trial (Dec-14 - Feb-15), trial (Mar-15 - May-15), post-trial (Jun-15 - Aug-15) and follow-up (Dec-15 - Feb-16). Where data is presented for non-trial wards, these figures only include wards that are classified as the same type of services as those included in the trial, i.e. adult, adolescent/youth, aged, and SECU. There were 54 non trial wards included in the data analysis.

The number of admissions for each time period varied overtime and by ward, across all wards the trend was more admissions at follow-up than the pre-trial period (see table 5.1). The number of individuals admitted followed the same pattern within each ward as the number of admissions; however in Wards 4 and 5 each admission represented an individual. For all other wards it is common that some individuals were admitted multiple times during the specified 3-month period.

Table 5.1 number of admissions and number of individuals admitted per trial ward

	Pre-trial Dec-14 - Feb-15		Trial Mar-15 - May-15		Post-trial Jun-15 - Aug-15		Follow-up Dec-15 - Feb-16	
Ward	**admissions**	**individuals**	**admissions**	**individuals**	**admissions**	**individuals**	**admissions**	**individuals**
1	238	207	181	165	192	169	184	171
2	151	137	140	126	154	140	173	155
3	134	121	131	127	131	122	149	136
4	4	4	1	1	2	2	4	4
5	226	202	265	239	256	230	219	195
6	5	5	8	8	4	4	6	5
7	86	78	123	116	104	102	144	135
8	97	90	109	99	97	93	95	88
9	26	26	24	21	28	28	37	32
10	161	152	160	144	160	140	163	143
11	152	144	146	132	176	160	181	164
12	125	115	167	153	174	159	188	170
13	88	81	92	85	110	99	121	112
14	88	77	114	102	120	112	115	103
15	178	156	163	147	183	171	157	142
16	161	149	166	152	196	167	209	194
17	46	41	50	49	53	49	42	41
18	21	15	17	14	18	13	24	15
Total	1987	1800	2057	1880	2158	1960	2211	2005

Table 5.2 highlights that the use of seclusion is variable across Safewards trial wards, where some wards had no seclusions for a given time period and other wards had up to 61 seclusions. In the majority of wards a small number of individuals account for a majority of the seclusion events. The average length of seclusion varies considerably across wards and over time.

Table 5.2 Number of seclusion events, individuals secluded & average length of seclusion event in minutes

	Pre-trial Dec-14 - Feb-15			Trial Mar-15 - May-15			Post-trial Jun-15 - Aug-15			Follow-up Dec-15 - Feb-16		
Ward	Events	Individuals	Ave. length (mins)	Events	Individuals	Ave. length (mins)	Events	Individuals	Ave. length (mins)	Events	Individuals	Ave. length (mins)
1	13	10	918.7	31	16	248.6	49	22	297.6	45	15	262.2
2	39	21	1187.7	60	20	624.2	37	17	1531.1	29	12	1498.6
3	31	17	922.2	19	13	1377.4	25	17	1123.7	36	20	2124.7
4	0	0		0	0		0	0		0	0	
5	8	5	160.9	10	7	250.1	2	2	655.0	3	2	190.0
6	0	0		0	0		0	0		0	0	
7	57	15	370.9	38	20	333.1	61	17	364.1	31	15	297.0
8	9	6	295.5	10	7	503.4	9	8	432.9	3	3	289.0
9	0	0		2	1	136.0	0	0		1	1	310.0
10	20	12	287.3	20	12	249.7	23	8	371.0	11	8	470.5
11	21	14	178.3	15	12	253.1	7	5	174.6	9	5	116.3
12	21	11	313.5	13	10	280.4	36	16	372.7	35	17	490.9
13	49	11	172.9	14	7	150.7	24	12	96.3	8	5	223.9
14	13	3	200.8	2	2	121.7	0	0		6	5	52.2
15	9	7	313.6	8	4	196.5	22	12	768.1	8	7	503.0
16	30	22	339.0	40	16	456.1	54	24	621.1	36	21	352.9
17	4	2	283.3	0	0	35.0	0	0		5	3	216.0
18	1	1	163.3	4	4	290.0	0	0	167.5	2	2	426.0

Pre and post-Safewards trial seclusion analysis

This section provides data and analysis of seclusion rates in the pre-trial period and the post-trial period. Comparisons are made between pre and post seclusion rates for individual wards, as well as between trial and non-trial sites and between the four service types.

Figure 5.1 shows the number of seclusion events per 1000 occupied bed days for each individual ward that implemented Safewards. The bar graph indicates a great deal of variability between wards. Six out of the 18 wards showed increased seclusion rates from the pre-trial to the post-trial period. Three wards did not have any seclusion events at all and a further two wards had zero seclusions in the post-trial period. The remaining six wards showed reductions in seclusion rates.

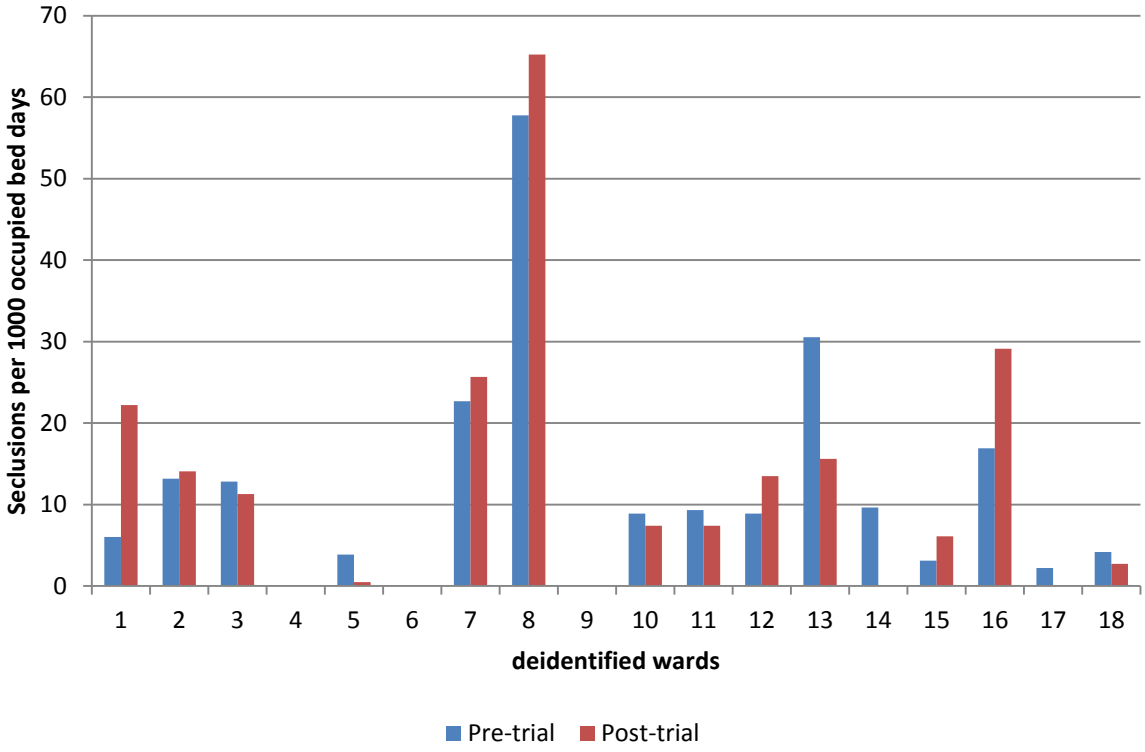


Figure 5.1 Seclusions per 1000 occupied bed days pre and post –trial, individual de-identified wards

For the 18 trial wards, the mean number of seclusions per 1000 occupied bed days rose during the analysis period (Table 5.3). A paired t-test of was used to establish if there was a statistically significant mean difference between rates of seclusion per 1000 occupied bed days prior to and after the implementation of Safewards. There was no significant difference found in the rates of seclusion prior to and after the implementation of Safewards, at the .05 level of significance.

Table 5.3 Results of t-test and Descriptive statistics for rates of seclusion, between pre and post-trial

	Pre-trial			Post-trial			mean difference	95% CI for mean difference	t	df	p
	M	SD	n	M	SD	n					
Seclusions per 1000 occupied bed days	11.67	14.10	18	12.26	16.18	18	-.59	-4.09, 2.90	-0.36	17	0.72

The rates of seclusion per 1000 occupied bed days were then graphed to establish if the pattern of increase seen in Safewards sites was different to the rates in non-trial sites. Figure 5.2 (overpage) illustrates that in both groups the rate of seclusion increased between the pre- and post-trial period. It further illustrates that the Safewards trial sites had a seclusion rate almost double the other sites, both before and after the introduction of Safewards. However the trendline for trial sites indicates a clear downward trend in the use of seclusion over the entire trial and follow up period. Conversely, for the same points in time the sites not involved in Safewards show a clear upward trend in the use of seclusion.

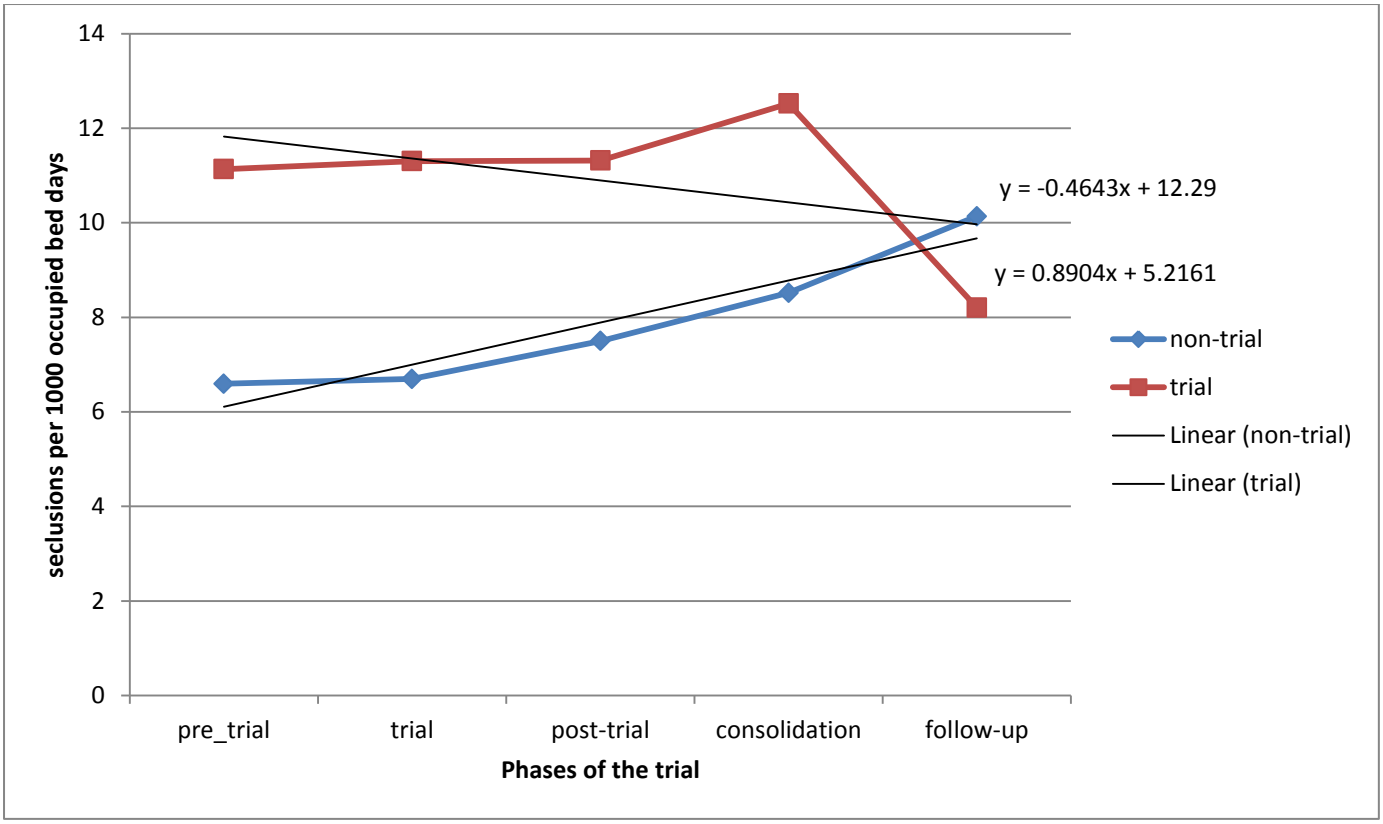


Figure 5.2 Seclusions per 1000 occupied bed days comparing pre and post-trial phases with Safewards sites and other sites

Figure 5.3 displays the rates of seclusion per 1000 occupied bed days for all wards involved in the trial, grouped by services types. The graph shows that rates of seclusion are much higher in adult and adolescent/youth wards than in aged and SECU wards. Further it shows that only adult wards experienced an increase in seclusion events between the pre and post-trial periods. However by follow up adult and adolescent/youth wards had made good reductions in the use of seclusion. In contrast, the use of seclusion in SECU and aged persons services was very minimal and hovered between 0 and 2 seclusions per 1000 occupied beddays over the course of the trial.

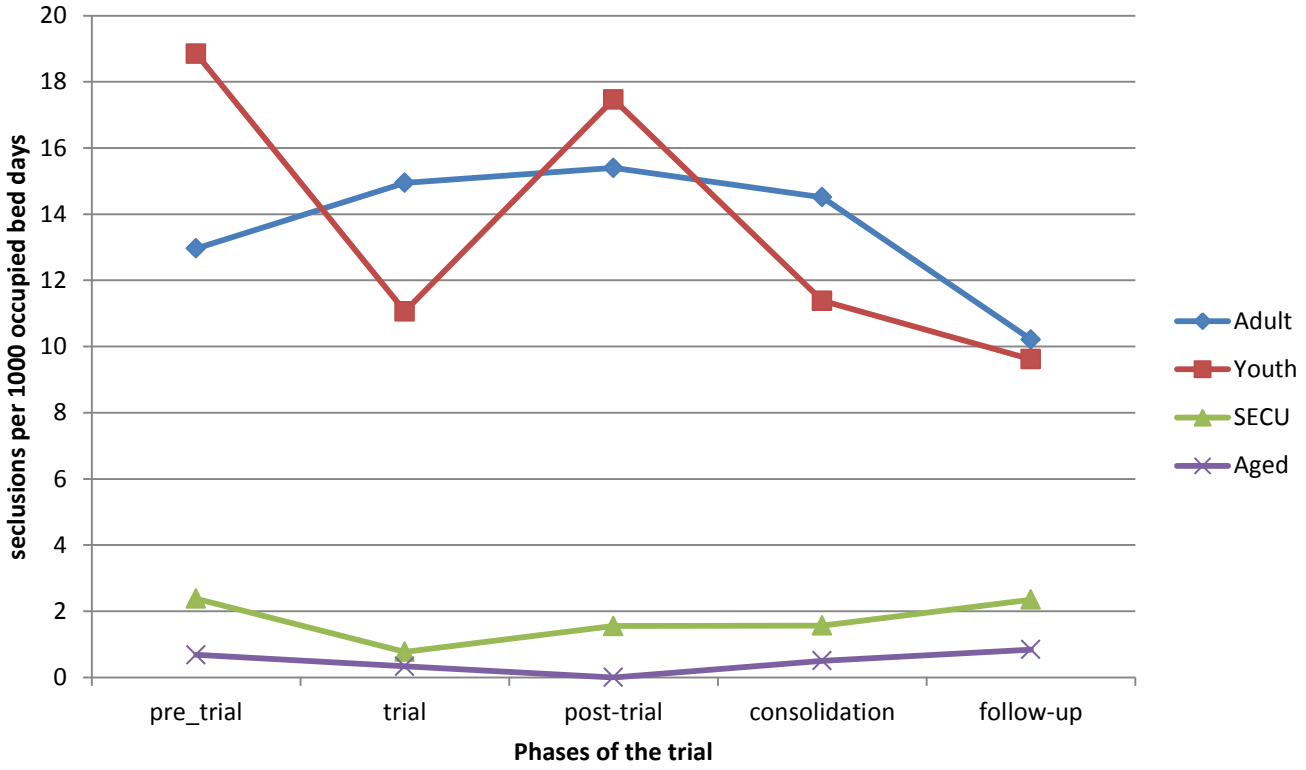


Figure 5.3 Seclusions per 1000 occupied bed days pre and post-trial, for ward implementing Safewards by service type

To make comparisons between trial and non-trial wards, a change score was calculated for rates of seclusion per 1000 occupied bed days and the pre-trial seclusion rate was subtracted from the post-trial seclusion rate. A paired t-test was used to establish if there was a statistically significant mean difference in change scores between the trial wards and non-trial wards. There was no significant difference found in the rates of seclusion prior to and after the implementation of Safewards between trial and non-trial sites, at the .05 level of significance (Table 5.4). However the negative mean indicates that, although not significant, the rates of seclusion declined for the youth/adolescent, aged, and SECU wards in the trial. The same pattern was observed for the aged care wards in the non-trial sites. Whereas for the adult, youth/adolescent and SECU wards in the non-trial sites, the rates of seclusion have increased. The t-test results indicate a trend that Safewards trial sites are improving their rates of seclusion albeit without significance.

Table 5.4 Results of t-test and Descriptive statistics for the change in rates of seclusion, for each service type involved and not involved in the Safewards trial

Service Type	Safewards			Non Safewards			mean difference	95% CI for mean difference	t	df	p
	M	SD	n	M	SD	n					
Adult	2.67	5.82	10	0.53	24.45	21	-2.14	-18.30, 14.02	-0.27	29	0.79
Adolescent	-4.11	14.40	3	1.22	3.12	8	5.32	-5.90, 16.54	1.07	9	0.31
Aged	-0.74	1.28	3	0.68	1.53	16	1.42	-.57, 3.41	1.50	17	0.15
SECU	-0.72	1.02	2	-0.51	1.16	9	0.21	-1.81, 2.24	0.24	9	0.82

Pre Safewards and follow-up comparison analysis

This section provides data and analysis of seclusion rates in the pre-trial period and the follow-up period. Comparisons are made between pre and follow-up seclusion rates for individual wards, as well as between trial and non-trial sites and between the four service types.

Figure 5.4 shows the number of seclusion events per 1000 occupied bed days for each individual ward that implemented Safewards. The bar graph indicates a great deal of variability between wards. Five out of the 18 wards showed increased seclusion rates from the pre-trial to the follow-up period. Two wards did not have any seclusion events at all. The remaining eleven wards showed reductions in seclusion rates, the seclusions per 1000 occupied bed days reduced markedly in some wards, for example ward '8' went from 58 to 11 seclusions per 1000 occupied bed days, from pre-trial to the follow up period.

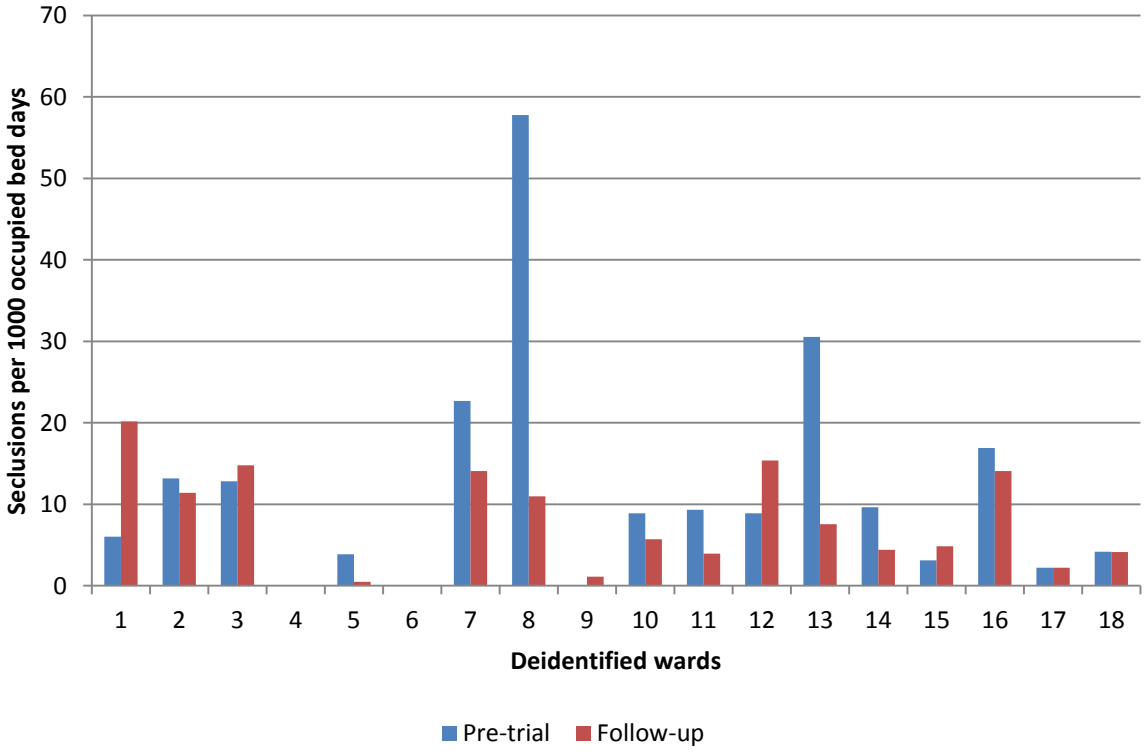


Figure 5.4 Seclusions per 1000 occupied bed days pre and post –trial, individual de-identified wards

Over all the trial sites there is a reduction in seclusion from the pre-trial period to the follow-up period. Whereas for the non-trial sites seclusions per 1000 occupied bed days increased. This is illustrated in figure 5.5.

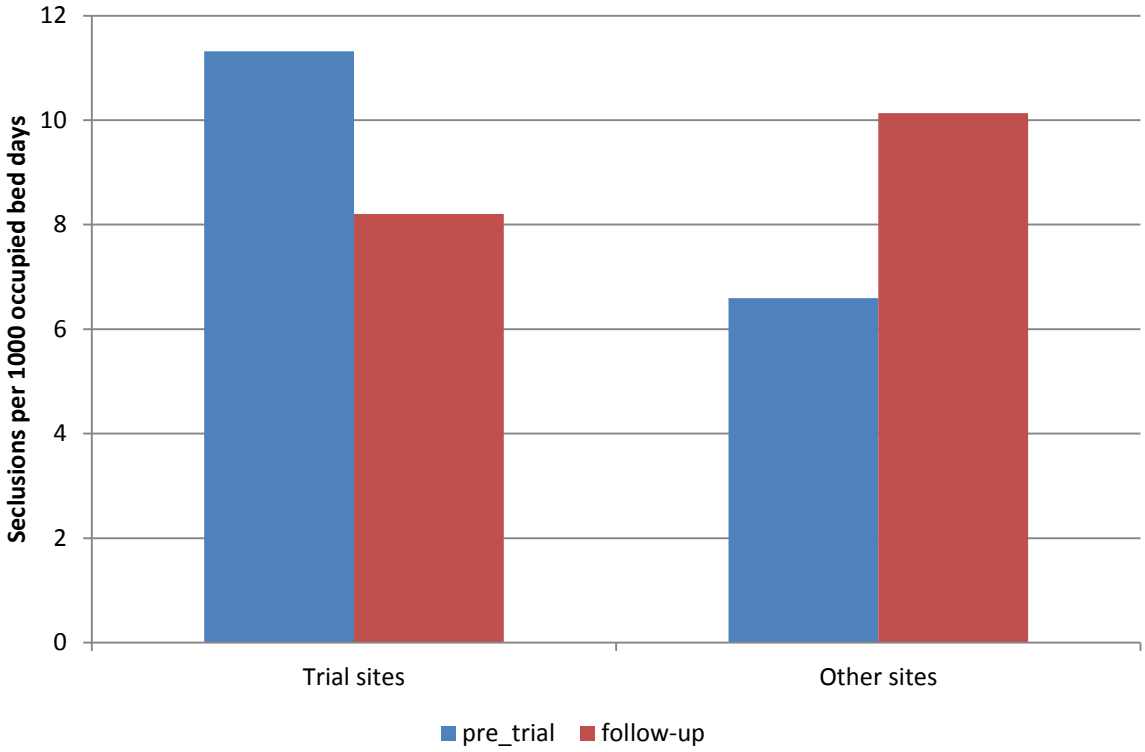


Figure 5.5 Seclusions per 1000 occupied bed days comparing pre and follow-up trial phases with Safewards sites and other sites

A paired t-test was run on the 18 trial wards to establish if there was a statistically significant mean difference between rates of seclusion per 1000 occupied bed days prior to Safewards implementation and 12 months later at follow-up. There was no significant difference found in the rates of seclusion prior to and after the implementation of Safewards, at the .05 level of significance. The mean number of seclusions per 1000 occupied bed days decreased during the analysis period (Table 5.5). Although non-significant, there is a trend towards less seclusions per 1000 occupied bed days across trial sites at follow-up.

Table 5.5 Results of t-test and Descriptive statistics for rates of seclusion, between pre and post-trial

	Pre-trial			Follow-up			mean difference	95% CI for mean difference			
	M	SD	n	M	SD	n			t	df	p
Seclusions per 1000 occupied bed days	11.67	14.10	18	7.511	6.248	18	4.15	-2.25, 10.56	1.37	17	0.19

Figure 5.6 displays the rates of seclusion per 1000 occupied bed days for wards involved in the trial, grouped by services types. The graph shows that rates of seclusion are much higher in adult and adolescent/youth wards, than aged and SECU, similar to the pre and post-trial period graph. Further it shows that the adult wards experienced an increase in seclusion events between the pre-trial and follow-up periods. Whereas the adolescent/youth wards displayed a substantial decrease between the two time periods, almost halving their rate of seclusions per 1000 occupied bed days from 18.8 to 9.6. In contrast Aged wards and SECU's were relatively constant between the two time points, and between post-trial and follow-up the seclusion rates in aged wards increased.

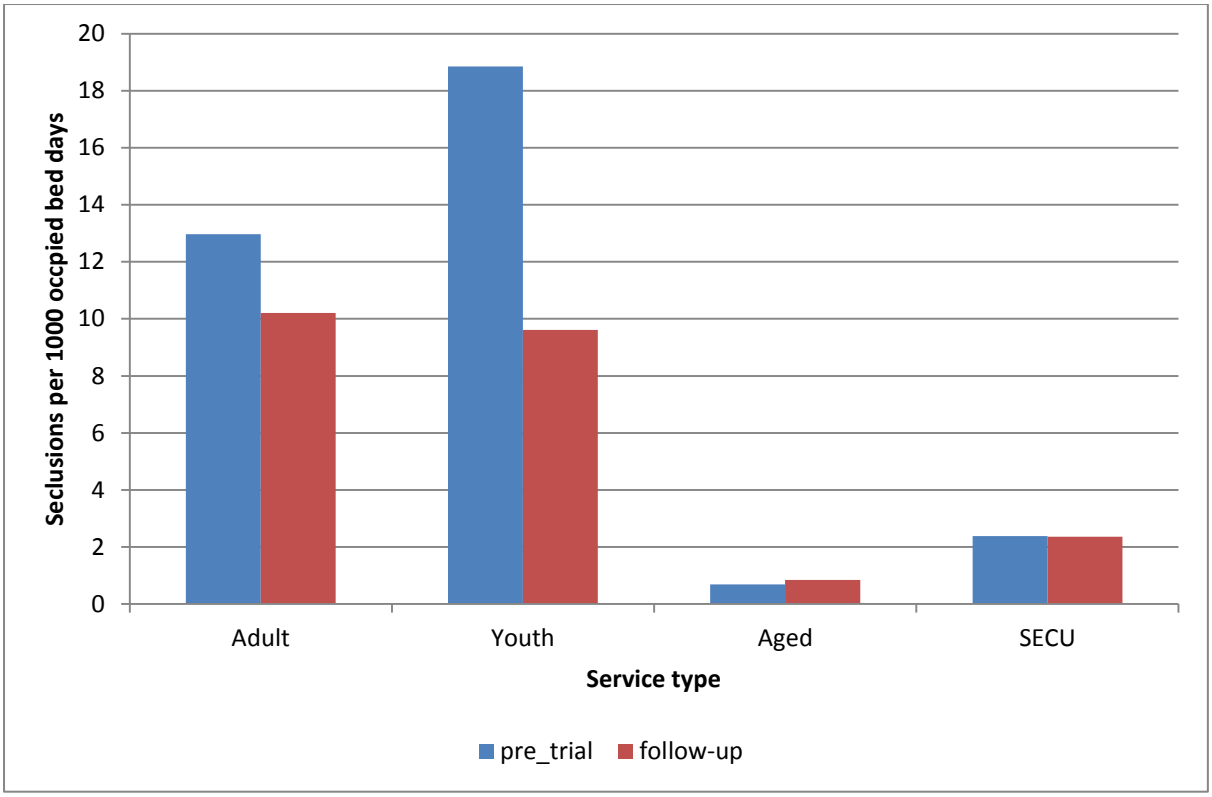


Figure 5.6 Seclusions per 1000 occupied bed days pre- trial and follow-up, for each service type

To make comparisons between trial and non-trial wards a change score was calculated. A paired t-test was used to establish if there was a statistically significant difference in change scores between the trial wards and non-trial wards. There was a significant difference found in the rates of seclusion prior to and after the implementation of Safewards, between trial and non-trial sites for adolescent/youth services.

In contrast, there was no significant difference found at the .05 level of significance in the rates of seclusion prior to and after the implementation of Safewards, when wards were grouped as trial and non-trial sites (Table 5.6). However the negative mean indicates that, although not significant, the rates of seclusion also declined for the aged, and SECU wards in the Safewards trial. Seclusion rate also declined for the aged care wards in the non-trial sites. Whereas for the adult, youth/adolescent and SECU wards in the non-trial sites, the rates of seclusion have increased.

The t-test results indicate a trend that Safewards trial sites for adult, aged and SECU wards are improving their rates of seclusion, albeit without significance. The Safewards youth wards demonstrated a statistically significant reduction in seclusion from pre-Safewards to follow up.

Table 5.6 Results of t-test and descriptive statistics for the change in rates of seclusion, for each service type involved and not involved in the Safewards trial

Service Type	Safewards			Non Safewards			mean difference	95% CI for mean difference	t	df	p
	M	SD	n	M	SD	n					
Adult	-4.48	16.21	10	6.61	26.36	20	11.09	-7.61, 29.79	1.21	28	0.23
Adolescent	-10.35	11.02	3	0.86	1.23	8	11.21	3.08, 19.33	3.12	9	**0.01***
Aged	0.36	0.64	3	2.15	3.87	16	1.79	0.13, 3.60	0.78	17	0.44
SECU	-0.02	0.03	2	0.36	3.01	9	0.38	-4.64, 5.41	0.17	9	0.87

*significant difference in seclusion rate between Safewards youth wards and non-Safewards youth wards

Overall, the results of analyzing the seclusion data from the pre to post trial period are equivocal. However in the period from pre-trial to follow-up a year later, Safewards wards are showing a promising downward trend in the use

of seclusion in Adult, Aged wards and SECU's and a significant difference between trial and non-trial adolescent/youth services in this period.

Chapter 6 Results: Consumer experiences and perceptions of Safewards

Consumer feedback about Safewards was gathered at two time-points in the project: a focus group was held with Consumer Consultants in May 2015, at the completion of the trial period and consumer surveys were completed in January-March 2016, with consumers in the trial wards. Consumer Consultants provide a unique role in Victorian mental health services. Rather than engaging in direct service provision, Consumer Consultants are often working at the level of supporting change within organisations through the strategic use of their own experiences, for example, by working with services to achieve a recovery orientation and improve the experience of consumers. As such, their connection to Safewards was largely via contact with consumers in wards, and observation of the work in wards. These data provide important insights into the experience of Safewards for the people it is intended to benefit.

Safewards consumer surveys

This section of the report provides detailed analysis of Consumer survey responses. Consumer surveys were completed by 72 people between February-March 2016.

Demographics

Table 6.1 Survey respondent demographics

	frequency	%
Gender n=60		
Male	29	48.3
Female	31	51.7
Other	0	0.0
Language n=59		
English	54	91.5
Other	5	8.5
Aboriginal Torres Strait Islander Status n =60		
No	58	96.7
Aboriginal	2	3.3
Torres Strait Islander	0	0.0
Both	0	0.0
Age mean and range	40 years	18-78

Table 6.2 Health services of consumers

Health Service n = 60	frequency	%
Albury/Wodonga Health	0	0.0
Alfred Health	19	31.7
Bendigo Health	18	30.0
Latrobe Health	12	20.0
Melbourne Health	0	0.0
Mercy Health	0	0.0
Monash Health	11	18.3

Table 6.1 and 6.2 characterise the 72 consumers who responded to the survey: men and women participated equally, a minority spoke a primary language other than English and a small minority were Aboriginal, and the mean age was 40 years (18-78). The table also indicates where consumers who completed the surveys experienced Safewards, in terms of which participating services and service types. Five health services were represented in consumer surveys, and Bendigo Health and Alfred Health together represented 50% of the consumers surveyed. The majority of consumers were from adult services (64%), however all services types were represented by consumers.

Use of Safewards

Consumers were asked about their knowledge and experience of Safewards and 10 interventions (see Table 6.3).

Table 6.3 Consumers recall of the use of interventions

Intervention Consumer n = 70	Yes %	No %	Unsure %
Clear Mutual Expectations	33.3	44.9	21.7
Soft Words	46.4	30.4	23.2
Talk Down	29.0	49.3	21.7
Positive Words	47.8	34.8	17.4
Bad news mitigation	21.7	46.4	31.9
Know each other	66.7	20.3	13.0
Mutual help meeting	81.2	10.1	8.7
Calm down methods	62.3	18.8	18.8
Reassurance	53.6	24.6	21.7
Discharge messages	68.1	21.7	10.1

Most consumers had heard of the program Safewards itself (59%), and the survey participants knew of at least one intervention. Most consumers knew of five of the 10 Safewards interventions: *mutual help meeting*, (highest at 81%), *discharge messages, know each other, calm down, reassurance* (53%). *Bad new mitigation* was the intervention least known by consumers (22%).

Consumers were asked to rate ***how frequently*** they used or were involved in the model and interventions (Figure 6.1).

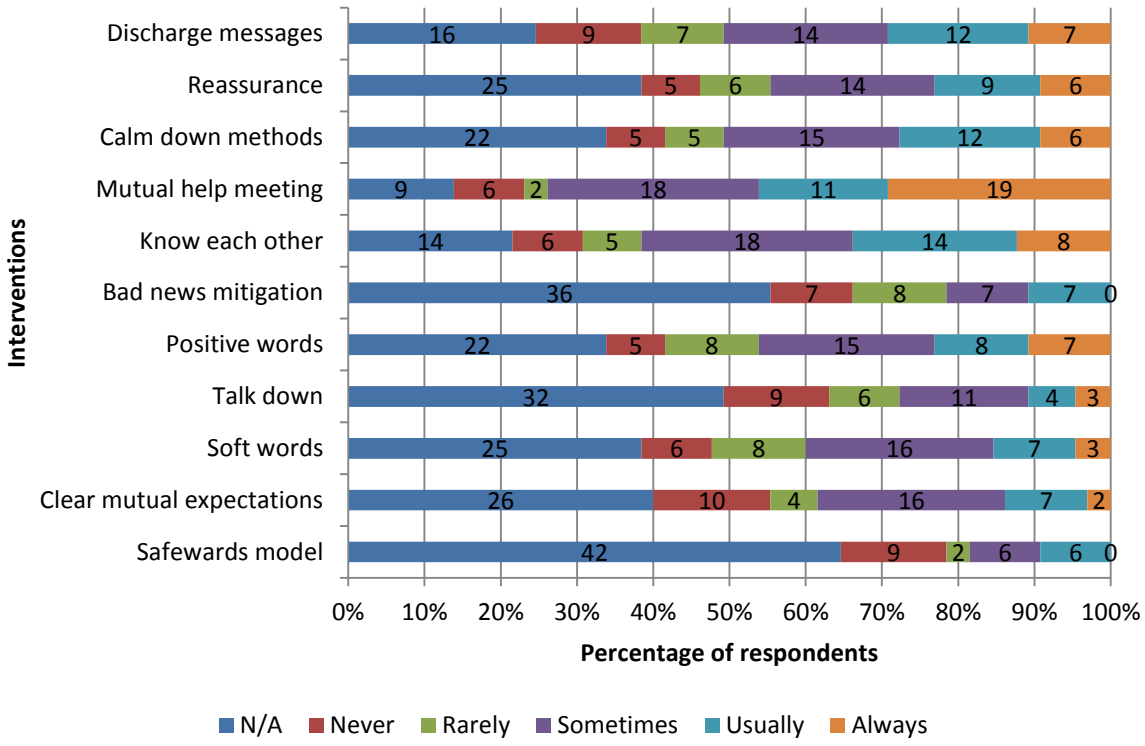


Figure 6.1 Consumer frequency of involvement in Safewards & 10 interventions (n = 65)

It is reasonable to expect consumers to be aware of five of the interventions in particular, if they have experienced them, given that these interventions require direct contribution from the consumer. The intervention that by far the most consumers experienced frequently was the *mutual help meeting*, followed by *know each other, discharge messages* and *calm down*. These interventions are among those that require active engagement of the consumer, when compared with, for example, *soft words* or *reassurance*. Those require staff initiated communications, and another intervention, *positive words*, centres on the between-staff handover, out of view of consumers. The model itself and the interventions of *bad news mitigation* and *talk down* were least prominent for consumers.

Consumers were asked to rate ***how worthwhile*** they believed the Safewards model and 10 interventions were for their unit (answers were on a likert scale 1 'poor', 2 'fair', 3 'good', 4 'very good', 5 'excellent') See figure 6.2.

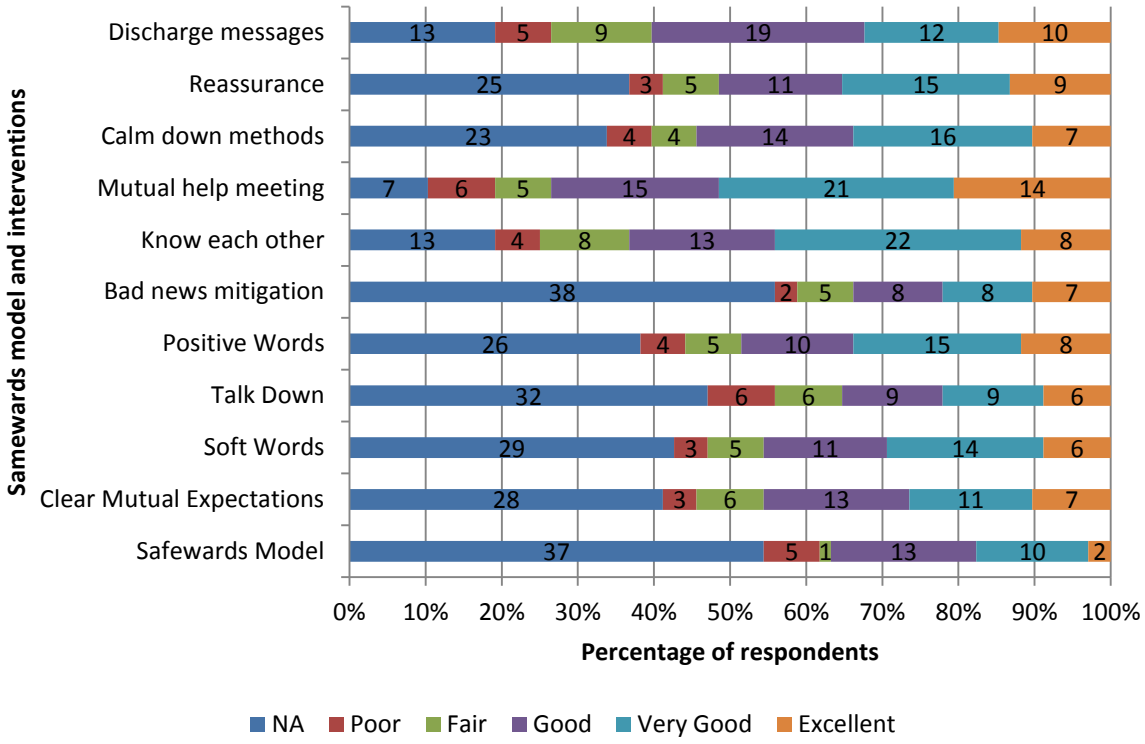


Figure 6.2 Consumer rating of how worthwhile are Safewards & 10 interventions

For the model and some interventions, consumers reported 'NA' up to 55% of the time. The percentage of consumers who reported they could therefore rate the intervention is presented in brackets, being: *discharge messages* (80%), *calm down methods* (65%), *mutual help meeting* (90%), *know each other* (80%) and *clear mutual expectations* (60%). Consumers were most positive about the worth of the *mutual help meetings* and *know each other* interventions, with approximately 50% of respondents rating these as 'very good' or 'excellent'. Sixty percent of consumers rated *discharge messages* as either 'good', 'very good' or 'excellent'.

Consumers also reported the worth of these interventions as very good: *reassurance, know each other, bad news mitigation, positive words*. A small minority of respondents (3-9%) rated an intervention as poor (least often for BNM, most for MHM).

Impact of Safewards

Consumers were asked to consider four flashpoints that are known to occur on inpatient units and to rate how often these flash points had been resolved more quickly than usual. Fifty-nine consumers provided their answer to this question and ratings for this question were on a five-point likert type scale where 1 = 'never', 2 = 'rarely', 3 = 'sometimes', 4 = 'usually' and 5 = 'always', participants also had the option to select unsure.

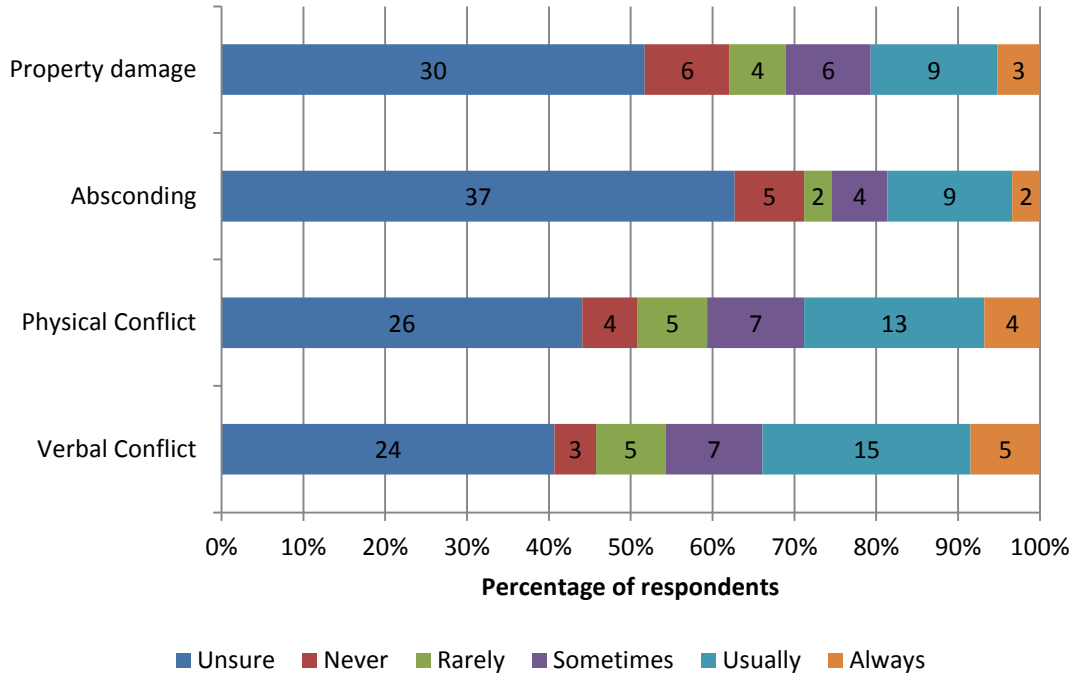


Figure 6.3 Impact of Safewards on flashpoint resolution

Figure 6.3 displays the frequency with which staff and consumers perceive that flashpoints have been resolved more quickly than usual.

Of the 59 consumers who answered this question, few responded that the Safewards '**never'** had an impact (from 5% re verbal conflict to 10% re property damage). A similar proportion of 5-9% said Safewards did **'always'** have an impact in these situations. A majority of 40-62% (less re verbal conflict, more re absconding) were 'unsure' if Safewards had an impact. In regard to verbal conflict, 25% consumers said it 'sometimes', 'usually' or 'always' did have an impact. Overall, consumers were not certain of a relationship between Safewards and resolution of flashpoints, but cautiously positive about its impact.

Consumers were provided with six statements about staff engagement with Safewards and about more general aspects of their experiences on the ward (Q18) and asked to rate the extent to which they agreed on a 5-point likert type scale where 1 = 'never', 2 = 'rarely', 3 = 'sometimes', 4 = 'usually', 5 = 'always'.

Figure 6.4 provides the percentage of agreement about each statement from the consumer perspectives.

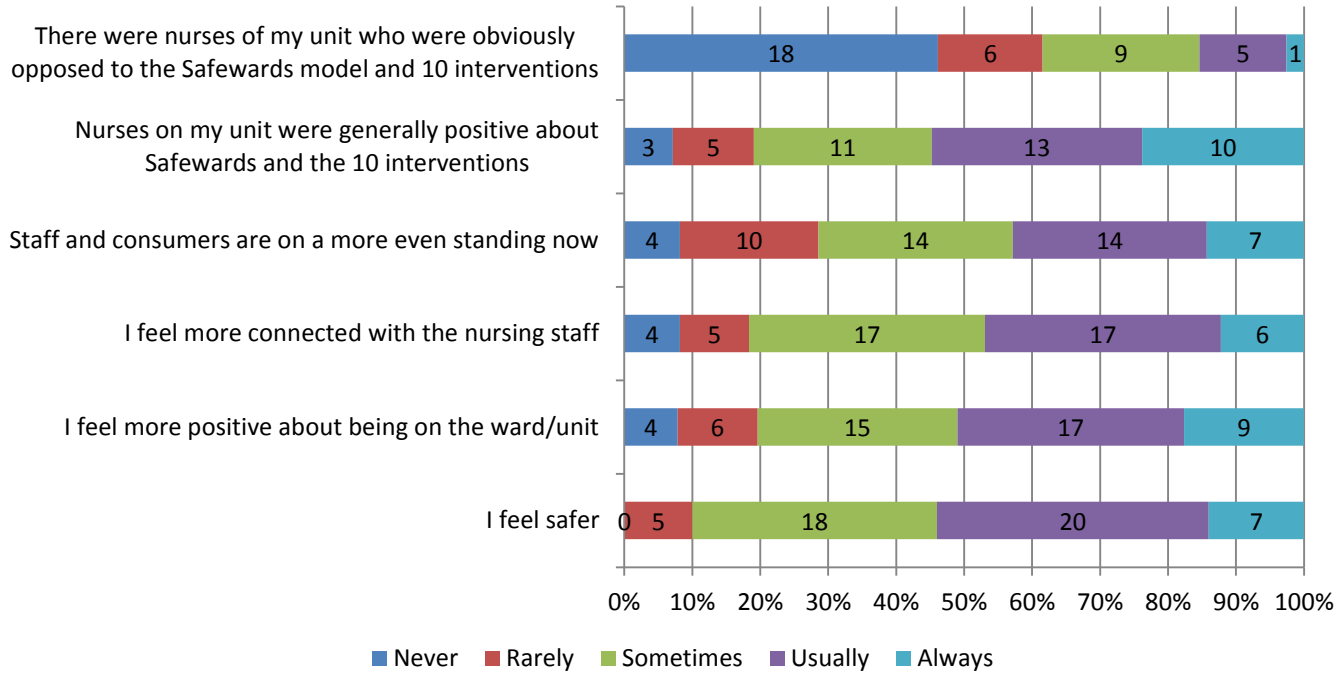


Figure 6.4 Consumer rating of impact of Safewards on ward experience

Of the consumers (n=51) who responded to this question, most affirmed the statements about an improved ward experience. The most striking finding is that **more than half of consumers said they 'usually' or 'always' felt safer and more positive on the ward**, since Safewards was introduced. They also felt that they were 'sometimes' or 'usually' more connected and on a more even footing with staff, and that nurses were generally positive about Safewards. They felt nurses were 'rarely' or 'never' opposed to Safewards.

Elaborating consumer feedback

This section of the analysis systematically presents the qualitative feedback from consumer surveys. Consumers were invited to provide free text responses, with more detailed feedback regarding any elements of the Safewards model or practice they had rated as either poor or excellent. Where the comments clearly related to an intervention they are added to the analysis of comments provided specifically regarding individual interventions.

Nine individuals responded specifically with 13 comments related to poor elements, across the services. These were clustered in categories of general comments (n=8) or specific to an intervention (n=5).

Generally, consumers were sensitive to a poor standard of patient-staff communications: "*Inappropriate use of words. E.g. 'calm down'*" or "*Nobody talks to anyone here*"; or "*These [interventions] were not used by the nurses, medication was offered rather than talking*".

Some comments suggested concern about a wider culture that was unhelpful in the ward: "*Its like a school yard here*"; or of staff being disengaged with the interventions: "*Not all staff participated*" ; or of consumers not getting needs met: "*I feel like I'm not getting anywhere with getting help to go to the shops*".

Five consumers specifically commented on interventions as poor. One was in reference to MHM : "*Everyone says the same thing every week Not much variation Would like other activities*". Two comments of concerns about KEO, were: "*Know each other - depends on staff*" and noting a problem with looking after the KEO resource: "*Profile display was taken down by un well patient and not replaced*". One comment was made about the calm down resources being patronizing: "*Calm down box- it's for children. I don't think it's respectful to treat people as a child*." And one expressed concerns about the use of Talk down - "*talk down is done disrespectfully*." One comment was about the model overall: "*Didn't find it helpful*."

Taken together, the negative comments about Safewards, as an approach or about a specific intervention, were most often (10/13) about the perception of the strategies being mis-applied, rather than being intrinsically poor (3/13).

There were 18 individual responses from 14 individuals specifically with comments related to excellent elements of Safewards. These included: "*Excellent regarding very helpful"* and *"staff have been very helpful towards me*" and "*It has been very educational*". Several consumers referred to positive impact on a sense of personal safety: "*Keeps everyone calm*"; "*Useful and helps keep me safe and other patients calm as well*"; "*If inpatient you're in a dark place, these bring you back to reality, safe and hope*"; and "*Feel more safer and stronger*".

Specific interventions were identified by consumers as excellent. Most frequently identified was MHM, highlighted by consumers at three different sites: "*Helps get everyone's opinion*"; "*enjoy the meeting*"; "*I look forward to the meeting*"; "*People listened and it was facilitated well*."; "*Meetings on the couch is really good*"; and "*How we help each other and activities to get well this time*." This comment suggests a positive comparison with previous ward experience.

The most comprehensive comment provided, regarding MHM explicitly valued most of the meeting agenda:

> "*Helpful introduces you to people. Helps improve your stay. Gives your OT a better understanding of how to improve things on the ward. Thanks the people who have done positive things for you*".

Other interventions specifically identified as excellent were: Discharge messages: "*Give people motivation to get better (discharge messages)*"; Soft Words: "*Excellent" soft words for most staff*"; and Bad News Mitigation: "*Bad news done well usually, bad news could be "catastrophic" if not done properly*".

The consumer feedback about everyday details of their experiences of Safewards is complemented by the contribution of Consumer Consultants (n=4) who discussed in depth their perspective of Safewards, at the end of the trial period.

Consumer Consultants perspectives

The consumer worker focus group (duration of 78 minutes) gathered the experience of four consumer consultants and peer workers who were engaged in 5 of the acute wards undertaking in the Victorian Safewards trial. Though 11 consumer workers were invited, and 7 expressed interest in participating, only four could participate in the group due to the challenge of travel and part-time roles.

This focus group data is reported separately from the analysis of all other staff focus group data, because the perspectives provided by consumer workers were qualitatively different to those of clinical staff, arising from their different roles in the units and in the trial. That is, the consumer workers were not explicitly directed to undertake Safewards training or to use Safewards interventions themselves in their everyday work. While consumer workers were welcomed in the central and local training, direct consumer worker roles in Safewards were not established across the Victorian Safewards Trial implementation sites.

Rather, these participants brought their expertise, as people who have experienced inpatient care in public sector services and who also influence practice and service systems, through their governance roles in services, including hearing and responding to consumer complaints. They contributed insights from their own observations, feedback from peers and consumers and their own critical reflection on the potential of the model and interventions. Analysis of consumer and other views suggest that the integration of consumer workers in Safewards in future work would be a valuable and welcome development.

The focus group participants were well-aware of Safewards in their work environments. Their discussion offered three main themes: understanding the contribution of Safewards for consumers, consumers' own roles within Safewards; and consumer recommendations for sustaining and strengthening Safewards.

Understanding the contribution of Safewards for consumers

The current and potential impact of Safewards was very evident to these focus group participants: each could describe the *talk down* posters, *discharge messages* and *know each other* displays. The prominent *discharge message* trees were "a nice feature as you trot up the hall, on trend, with decals", contributing welcomed colour and communicating a cared-for space. These visual cues were also significant, because: "If you look around for mental health stuff, or at hospital signage, rarely is it cheerful". The authentic advice within *discharge messages* could provide powerful encouragement.

The visual features in the space were seen as not merely displaying individual Safewards interventions, but as cumulative messaging that improved the tone in the inpatient environment:

> "There are lists or you know *mutual expectation*s that are put up and laminated and they're quite colourful and respectful and on the board, we have a community board, the Safewards information is on there as well."

For the group, the message underpinning Safewards was respect and dignity.

The powerful expression of respect displayed in *clear mutual expectations* posters could be used in sophisticated ways, for example as something that staff can refer to, rather than confronting consumers directly:

> " instead of a nurse saying 'I'm telling you the rules, this is what they are, and then conflict arising , … staff can refer people to what is on the walls, go and check those Mutual Expectations, this is what we can guarantee you as staff".

The practical aspect of Safewards was also affirmed; Safewards was recognised as demonstrating "the basic tools for getting along". This comment about a *mutual help meeting* illustrated the contribution:

> "She will allocate a nurse and then they'll come in and run the meeting, and it's a lovely thing because you know the nurse is demonstrating interest and the people, they're being heard and they're saying their thank yous and that's it. It's a really nice little thing that happens."

The group agreed that everyone benefits from multifaceted reminders within Safewards to take time to be sensitive to people's needs, in an acute inpatient unit:

> "If someone is crying or whatever they will go and look after that person. If someone needs to know where the laundry is, the patients do that amongst themselves. Safewards is the basic tools [for getting along] and we need reminding, like you don't yell at your children but you have to remind yourself."

Together, the innovation of *clear mutual expectations*, *discharge messages*, *know each other soft words* and *positive words* communicated recognition of all people in the ward as people, elevating the tone of respect and dignity. The group strongly affirmed Safewards because it affirms consumers.

Consumers' own roles within Safewards

Participants were clear that the active part played by consumers is fundamental to success of Safewards. They echoed the strongly positive perspective of consumers in the wards about the value of *mutual help meeting*. Thinking about the changing attitudes in the sector, they recalled being actively discouraged by nurses and doctors from assisting others, when they had been hospitalised in years past. These participants explored how the MHM affirms for consumers their own innate capacity and drive to be supportive of others in a similarly difficult personal

situation: “You know, no matter what bunch of consumers I have [in the MHM], … they know what mutual help is all about”.

The participants were alert to consumers themselves driving change:

> “The other thing that I think is a real culture shift is the baseline anxiety level and fears, and that sense of threat and aggressive behaviour and all the rest of it, has really changed. And *mutual help* is a big part of that.”

This comment shows how participants saw consumers as having a key role in ward culture, that intentionally increasing mutual support could reduce anxiety and fear on the ward. This may contrast with ideas staff and managers hold, that anxiety, fear and culture are primarily the responsibility of professional and managerial staff.

The Consumer Consultants themselves recognised the value of acting as role models, being knowledgeable about Safewards, being willing for example to contribute a *know each other* profile. One talked of prompting the *positive words* in handover:

> “With the positive words and the handover, sorry to jump in – I found with handover sometimes it gets that busy that it doesn’t happen. …so trying to teach that to the staff, that they’re going to start the day better, save themselves time, if they can just do a positive handover you know”.

The participants were also aware of taking a supportive role, allowing consumers and staff to take a lead. One participant was wary of stepping and taking over an intervention: “And what my role has been, has been the champion in the background rather than the foreperson”. They agreed there was a risk of a Safewards intervention being marginalised if it was seen to belong to the Consumer Consultant role: “Its not going to work if it is just my thing.” It was considered crucial to get staff involved in MHM:

> “importance of the informality of the [MHM] and getting crucial levels of staff involved” so that “it doesn’t fall to one or two staff and lose the power of being mutual.”

Parallel to the theme in staff surveys, consumers experienced Safewards as reconnecting them with the grass roots of consumers supporting one another.

CC recommendations for sustaining and strengthening Safewards

Having expressed a clear commitment to see this change embedded and extended, the groups put forward ideas and issues for sustaining Safewards. They saw value in providing more information to consumers and to carers about Safewards as a model, and as a priority in the ward. Their thinking was that the more people understood the principles of preventing conflict, the more they could mutually contribute. This was supported by a participant’s experience that consumers in one ward really enjoyed reading about and discussing the *talk down* poster displayed in a main corridor, though this is designed as a staff resource.

Participants recognised the need for refresher training at intervals and for continuing training, to capture new staff. They were enthusiastic to see consumers and carers engaged in the training too, as participants and co-trainers:

> “Definitely have formal structured but also informal training, and best practice would be as it was to a large extent with the new mental health act, that it be consumer and carer run training as well as, so co-training – I think that’s really important.”

The group considered that displayed materials would also need refreshing. They discussed what best to do with accumulated discharge messages over time, recognised the need to refresh and move signage, when it became stale: “moving something that is on one wall and putting it on another, because they’ve stopped noticing it.” The

program requires budget for maintenance, and persistence, for example when: “an unwell patient who is taking everything off the walls… we’ll get all that stuff and put it back up”.

The group saw value in ongoing monitoring and evaluation, at both the local and broader level.

> “Well one of the things that I think is crucial is tracking trends in consumers’ responses to this, and being able to pinpoint or at least flag that this is partially due to Safewards, and the currents in how people deal with each other, staff consumers, consumers to other consumers, that have changed comparatively recently, that you could say was a kind of pre Safewards approach anyway. So being able to you know evaluate and make notes about, I think that’s kind of important.”

Another emphasised point was the need for organisations to see the influences and aims of Safewards in a longer term context, not as a discrete project:

> “You said the word trend, and I think what we’re trying to educate is this is not a trend, this is the way we work, that Safewards is part of our work ethics and this is part of your job description.

This analysis of data from both consumer surveys and a focus group of consumer workers conveys a clear message from consumers, about strongly valuing the intent and the impact of Safewards.

Chapter 7 Results: Safewards staff experiences

Staff feedback about Safewards was gathered at two time-points in the project: focus groups were held with Staff in May 2015, at the completion of the trial period and staff surveys were completed in between December 2015 and April 2016, in the trial wards.

Safewards staff surveys

This section of the report provides detailed analysis of Staff survey responses. Staff surveys were completed by 103 staff between December 2015 and April 2016.

Demographics

Table 7.1 Survey respondent demographics

	frequency	**%**
Gender n = 76		
Male	22	28.9
Female	52	68.4
Other	2	2.6
Language n = 74		
English	70	94.6
Other	4	5.4
Aboriginal Torres Strait Islander Status n = 76		
No	76	100.0
Aboriginal	0	0.0
Torres Strait Islander	0	0.0
Both	0	0.0
Mean age	43 (21-61)	

Table 7.2 Health services of staff

Health Service n = 77	frequency	%
Albury/Wodonga Health	2	2.6
Alfred Health	8	10.4
Bendigo Health	36	46.8
Latrobe Health	6	7.8
Melbourne Health	0	0.0
Mercy Health	1	1.3
Monash Health	24	31.2
Service Type n = 76		
Adult	42	55.3
Adolescent/Youth	4	5.3
Aged	13	17.1
SECU	17	22.4

Table 7.1 and 7.2 characterise the 103 staff who responded to the survey: more women participated than men, a minority spoke a primary language other than English and no one was Aboriginal, and the mean age was 43 years (21-61). The table also presents the health service name and type and number of staff participants from each site. Seven out of eight health services had at least one staff member who responded to the survey. Bendigo Health

recorded the highest level of participation. The majority of staff was from adult services however, staff from all services types participated.

Table 7.3 The professional role of staff

Professional Role n = 72	freq	%
Clinical Nurse Educator	3	4.2
Nurse Unit Manager	5	6.9
Associate Nurse Unit Manager	7	9.7
Clinical Nurse Specialist	3	4.2
Registered Nurse	25	34.7
Enrolled Nurse	14	19.4
Consumer Consultant	1	1.4
Peer Worker	0	0.0
Other	14	19.4
Other Roles n = 77		
RRI Lead	5	6.5
Safewards Lead	7	9.1
Both RRI & Safewards Lead	4	5.2
Neither	61	79.2
Safewards Champion	31	30.1

Table 7.3 highlights the professional roles of staff and other portfolio roles they may have. Fifty-five percent of staff were registered or enrolled nurses and almost 20% of staff reported being from another professional group, this included occupational therapists, social workers, and medical staff. Twenty percent of staff held a portfolio as the Reducing Restrictive Interventions Lead or Safewards Lead or both.

Use of Safewards

Table 7.4 shows the percentage of staff who recall each intervention being used on their unit (Q6.). The interventions were used between 81% (*Mutual help meetings*) and 97% (*Positive words*) according to staff report.

Table 7.4 Staff recall of the use of interventions

Intervention	Staff n = 90		
	Yes %	No %	Unsure %
Clear Mutual Expectations	91.1	4.4	4.4
Soft Words	91.1	2.2	6.7
Talk Down	95.6	2.2	2.2
Positive Words	96.7		3.3
Bad news mitigation	86.7	5.6	7.8
Know each other	95.6	1.1	3.3
Mutual help meeting	81.1	10.0	8.9
Calm down methods	96.7	1.1	2.2
Reassurance	91.1	4.4	4.4
Discharge messages	94.4	2.2	3.3

Staff were asked to rate ***how suitable*** they believed the Safewards model and 10 interventions were for their unit (answers were on a likert scale 1 'poor', 2 'fair', 3 'good', 4 'very good', 5 'excellent').

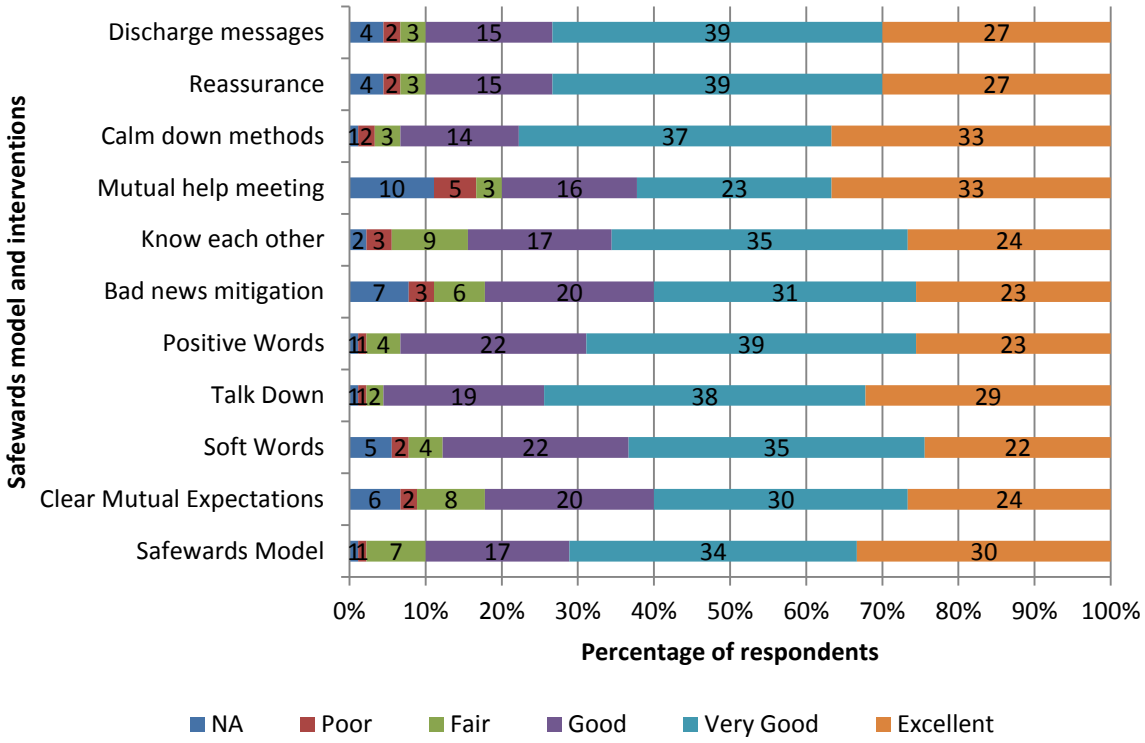


Figure 7.1 Staff report of the suitability of Safewards and 10 interventions

Figure 7.1 provides staff report of ***how suitable*** were Safewards and 10 interventions, in the main staff reported all interventions and the model to be highly suitable. There were some subtle differences, for example 10% of staff reported not being able to rate *mutual help meeting,* and around 10% of staff reported *know each other* to be 'fair' or 'poor'. *Talk down* and *positive words* received the most positive responses from staff in terms of suitability.

Qualitative responses summary

Staff who rated the Safewards model or one of the interventions as 'poor' were given the opportunity to provide a detailed comment. The following provides a thematic analysis of the responses provided by staff and consumers. Staff rated interventions as 'poor' between 1%-5% of the time, and eight staff provided 13 written comments about their responses. Three themes describe the 'poor' rating. The first theme highlights a staff view that the intervention is incompatible with nursing roles and responsibilities. For example a participant has a sense that their responsibility is greater than the patients and therefore the interventions are inappropriate. The following quote talking about *clear mutual expectations* illustrates this "not sure if everyone gets this idea, we can be called to account for our responses but a patient is not held to account". Another example of this was provided about soft words "e.g. with the [soft words] poster - apologise if you can't meet their request - sometimes people can take advantage of staff, we might know that the request is really not a good idea, is actually bad for the person"

The second theme relates to procedural concerns, some respondents reporting that the intervention was poor because there was no ownership taken for the intervention amongst the team. When talking about *discharge messages* for example the following comment was made "poor continuity of the intervention likely because there was no overseer". The third theme relates to a mindset that the illness of patients renders the intervention inappropriate. For example one staff member wrote about *soft words* "Mental state of some clients were unsuitable for soft words". When reflecting on *know each other* a staff member wrote "people are generally too unwell to use it in a positive manner, usually using it to target particular staff".

Staff who rated the Safewards model or one of the interventions as 'excellent' were also given the opportunity to provide a detailed comment. Three key themes summarise the detailed responses of staff regarding their rating of

the model or any of the interventions as 'excellent'. The themes are: *ward culture change*, *simple and relevant*, and *conflict prevention*. These three themes incorporate the views of 39 staff with 176 comments related to both the model and all 10 interventions.

The staff who highlighted a positive *ward culture change* described a change in the 'us and them' attitude, arising from sharing responsibility and increased collaboration between staff and patients. A number of mechanisms related to specific interventions facilitated this culture change. For example, commenting on *know each other* one staff member stated "Works well to reduce detachment between patients and staff and to build rapport". Likewise *mutual help meeting* contributed to positive culture change, as highlighted by this comment from a staff member "This is awesome because it make it about the patient and empowers them to have a say, and to be a part of what goes on around them during a time when a lot of choice is taken away". One staff member gave this comment about *positive words* "In an inpatient environment where there is a lot of negativity, utilising positive words (especially during handover and in clinical interactions with other staff) created a more professional, supportive & "positive" workplace".

The second theme *simple and relevant* again incorporates staff comments across the model and 10 interventions. Staff members put forward the idea that the model reminded them of their professional training and refreshed their thinking about providing more holistic care. This view is illustrated by this quote "If feels like we desperately needed something to remind us why we got into this nursing, it brings it back to basics and it brings it back to the patient." Staff affirmed that the model is clear and simple to follow, as the following quotes highlight "Easy to implement and adopt to current practice, useful for positive patient outcomes." and "Easy to follow and helps to keep the ward running smoothly and calmly". These sentiments were echoed when staff discussed specific interventions, for example in reference to *talk down:* "Structured process, easily to follow, assisted in reducing restrictive interventions, increased confidence."

The negative comments from staff came from a small subset of participants, who were likely to rate multiple interventions as 'poor' or 'fair'.

Staff were asked to rate the frequency with which they incorporated each of the Safewards interventions into their work. The rating scale for these questions was 1 = 'never', 2 = 'rarely', 3 = 'sometimes', 4 = 'usually' and 5 = 'always'.

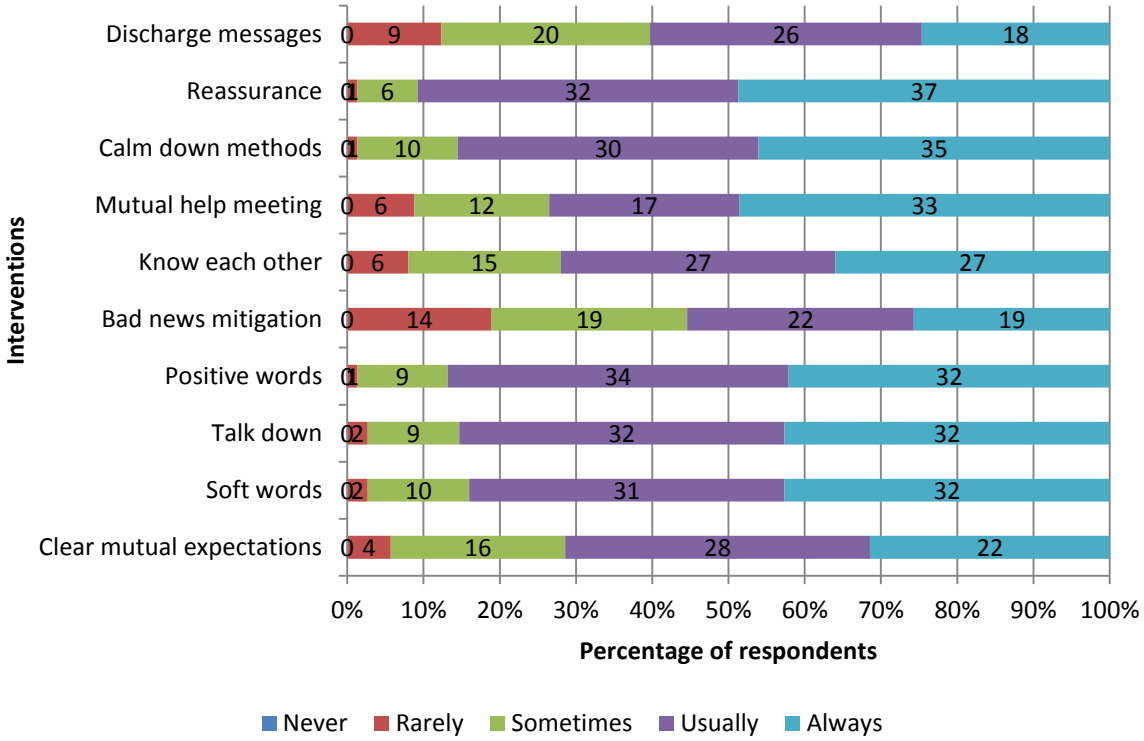


Figure 7.2 Staff frequency of use of the Safewards model and 10 interventions (n= 78)

The results displayed in figure 7.2 (the numbers inside the bars are the number of respondents) show how often staff report using each intervention. All interventions were reportedly utilised by all staff but four interventions stood out as rarely used: discharge messages (12%), mutual help meeting (8%), know each other (8%) and bad news mitigation (18%). The remaining interventions were reported to be utilised usually or always by between 70 - 90% of staff.

Implementation of Safewards: Staff perspectives

The implementation of Safewards was supported by a variety of components, including; the Safewards manual, the Safewards videos, the Safewards Facebook page, an intervention champion/s, and Safewards tools (including posters and articles). Staff were asked about each intervention separately and to rank the components in order of how useful they found each, so 'least useful' = 1 and 'most useful' = 5). Between 61 and 64 staff responded to this question about each intervention. The pattern of responses was the same for 9 interventions, the components were ranked in the following order; Safewards tools 'one' (most useful), Safewards champion 'two', Safewards manual 'three', Safewards video 'four' and Safewards Facebook page 'five' (least useful). The mutual help meeting was slightly different, champions were ranked the most useful followed by Safewards tools, the other components were ranked in the same order.

Consistency of implementation with training provided

Staff were asked to state if they believe the Safewards model and 10 interventions were implemented on their ward/unit as described in the training. Seventy-seven staff answered this question, of whom 83% responded affirmatively that implementation was consistent with training. Staff who believed that the implementation deviated from the training were asked to describe what was different and how. Fourteen staff provided detail as to how the interventions differed in implementation from the training. The comments were around two main themes. Modality: a number of staff reported that *know each other* profiles were displayed on TV screens instead of paper. The other

main difference reported was that for aged persons with cognitive impairment, amendments were made however examples were not provided.

Did using Safewards require you to change your approach to your work?

Eighty staff responded to the question regarding the need to change their approach to work and 49% of these stated that they did change their approach so that they were able to incorporate Safewards into their work. The staff that did change their work provided feedback regarding what these changes involved, 35 staff made comments. Increase in positivity was the most pervasive comment from staff, they were referring to having a more positive attitude and utilizing more positive language than they had in the past, for example "thinking about a more positive approach to ward and clients in interaction". A number of staff also reported being more reflective of their own practice and noticing that they were having more meaningful interactions with patients.

There was a small number of comments were made about Safewards being easily incorporated into work, when the staff member reported already working in a client-centered way. One person also noted that being a champion changed their "workplace thinking".

Did using Safewards in your ward/unit require changes to be made to the way your ward/unit worked?

Eighty staff responded to the question regarding the need for the ward/unit to change 71% of these stated that the workings of the ward/unit did change to incorporate Safewards into their work. Fifty-three staff provided feedback regarding what these changes involved. The most common theme from staff was that of a greater sense of team among the staff group "gave a baseline for everyone to work from". Having a collective understanding of the way to approach their 'work' was viewed positively. In line with comments about individual change to their own work, staff here also talked about the promotion of reflective practice. In the main the comments from staff were simply stating which interventions they implemented.

Level of service changes required to accommodate Safewards

Thirty-six staff provided feedback regarding individual practice level changes that had been made. Staff most commonly reported the changes required were to the attitudes of staff and language used. As well as participating in training and embracing new approaches to their practice.

Thirty-three staff provided feedback regarding unit level changes. Most of these comments reported the tangible changes that were made to the ward, such as the addition of Safewards posters, the 'Discharge tree' and 'Calm down' equipment. Increase collegial support and support from managers was also commented upon.

Twenty-two staff commented on wider service level change they observed. The most common change was acceptance of making changes for Safewards and ultimately to benefit consumers. Providing funding, spaces and enabling staff to attend training were also mentioned.

Implementation enablers and barriers

Seventy-seven staff provided feedback about elements that posed barriers to or enabled the implementation of Safewards, figure 7.3 below displays these results.

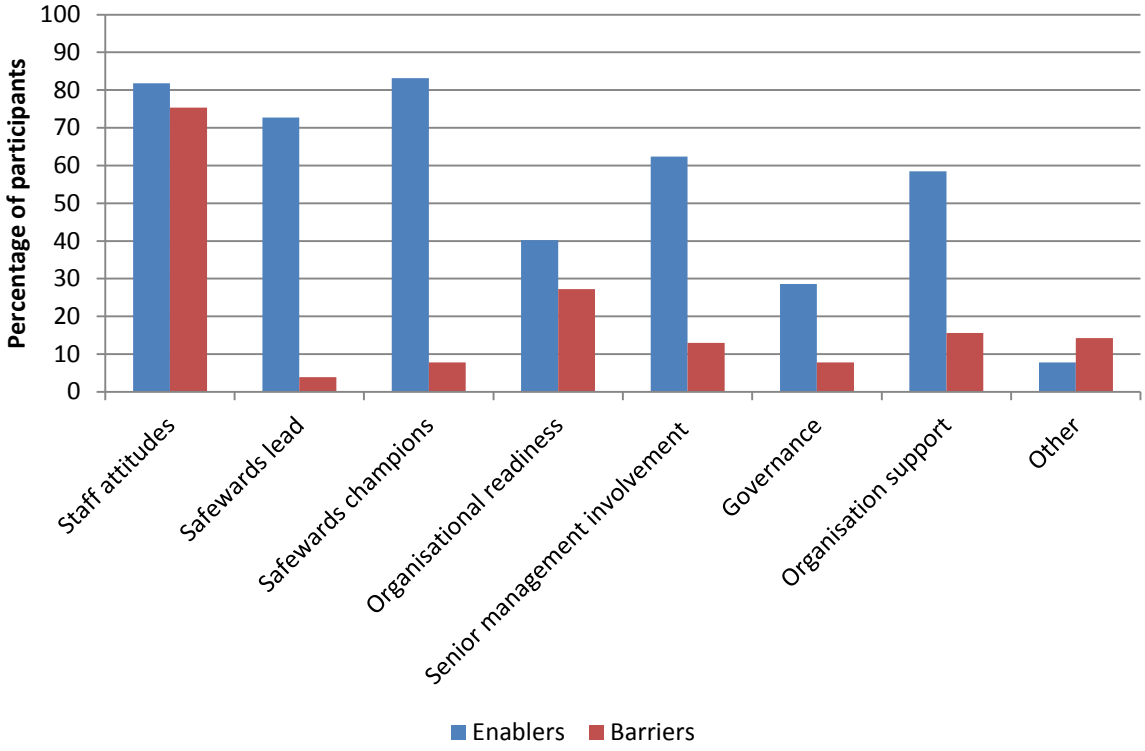


Figure 7.3 Percentage of participants identifying barriers and enablers to the implementation of Safewards

Staff attitudes were highlighted as both significant enabler and the greatest barrier to implementation, Safewards Lead and Safewards champions were both rated as important enablers to implementation. Organisational readiness was viewed to be the second most important barrier but was also rated as an enabler. Senior Management and Organisational support were both seen as enablers to implementation by around 60% of participants.

Inclusion of people with lived experience

Staff were asked how inclusive their unit was during the implementation of Safewards, they responded on a 5-point likert scale from 'poor' to 'excellent'. Seventy-seven staff responded to this question, the greatest proportion of staff reported their ward to be 'good' or 'very good' (36% and 30% respectively) 28% reported that their ward was either 'poor' or 'fair'. The remaining 6.5% of staff indicated their ward was 'excellent' in engaging consumers in the implementation of Safewards.

Impact of Safewards and the 10 interventions perspectives of staff and consumers

Staff were asked to consider four flashpoints that are known to occur on inpatient units and rate how often these flash points had been resolved more quickly than usual.

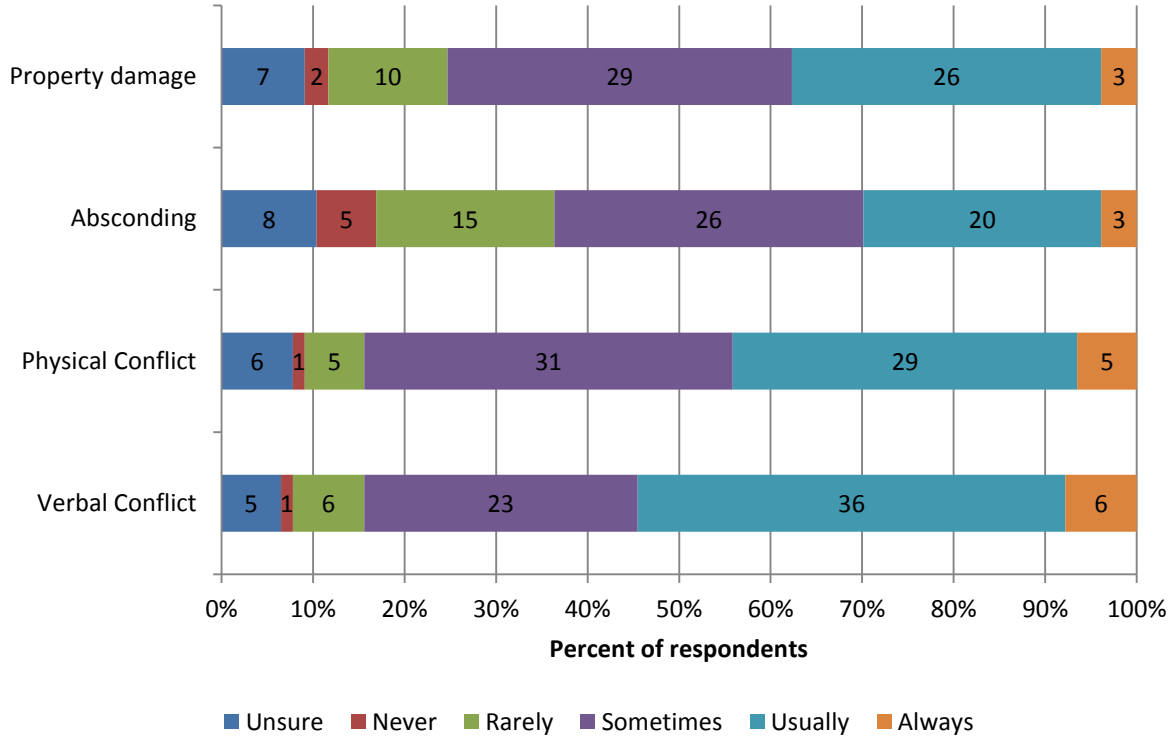


Figure 7.4 Flashpoint resolution

Seventy-seven staff provided their answer to this question. The ratings for this question were on a five-point likert type scale where 1 = 'never', 2 = 'rarely', 3 = 'sometimes', 4 = 'usually' and 5 = 'always', participants also had the option to select unsure. Figure 7.4 displays the frequency with which staff perceive that flashpoints have been resolved more quickly than usual. Verbal and physical conflicts were reported by around 85% of staff to resolved more quickly.

Staff were asked to consider an incident that they had some knowledge of which had a positive outcome using a Safewards intervention, which may have in the past resulted in a consumer being secluded, restrained or given PRN medication. Below are some examples of staff responses to this question:

> "Patient told staff he want to smash all the window. After 1:1 time, by using soft words, talk down, patient settled down and went to his bedroom."

> "Bad News Mitigation: [Consumers pet was his life and whilst admitted the pet died in very dramatic circumstances] the delivery of the bad news was well planned by staff, the consumer was fully supported with all needs met. This consumer had an extensive past history of impulse aggression, had required a lot of PRN medication and has had previous episodes of seclusion (the support provided resulted in the consumer appropriately expressing their emotions with nil medication or restraint required). Staff provided the consumer with all the time they needed to process this information in a very well coordinated and supported environment."

> "As young patient in a highly distressed state attempting to abscond was treated with respect and dignity. Given time to vent and offered reassurance, calm words, resulting in the use of sensory modulation, replacing seclusion."

Figure 7.5 below displays staff responses to statements about Safewards on their ward. The ratings for this question were on a five-point likert type scale where 1 = 'never', 2 = 'rarely', 3 = 'sometimes', 4 = 'usually' and 5 = 'always'. .

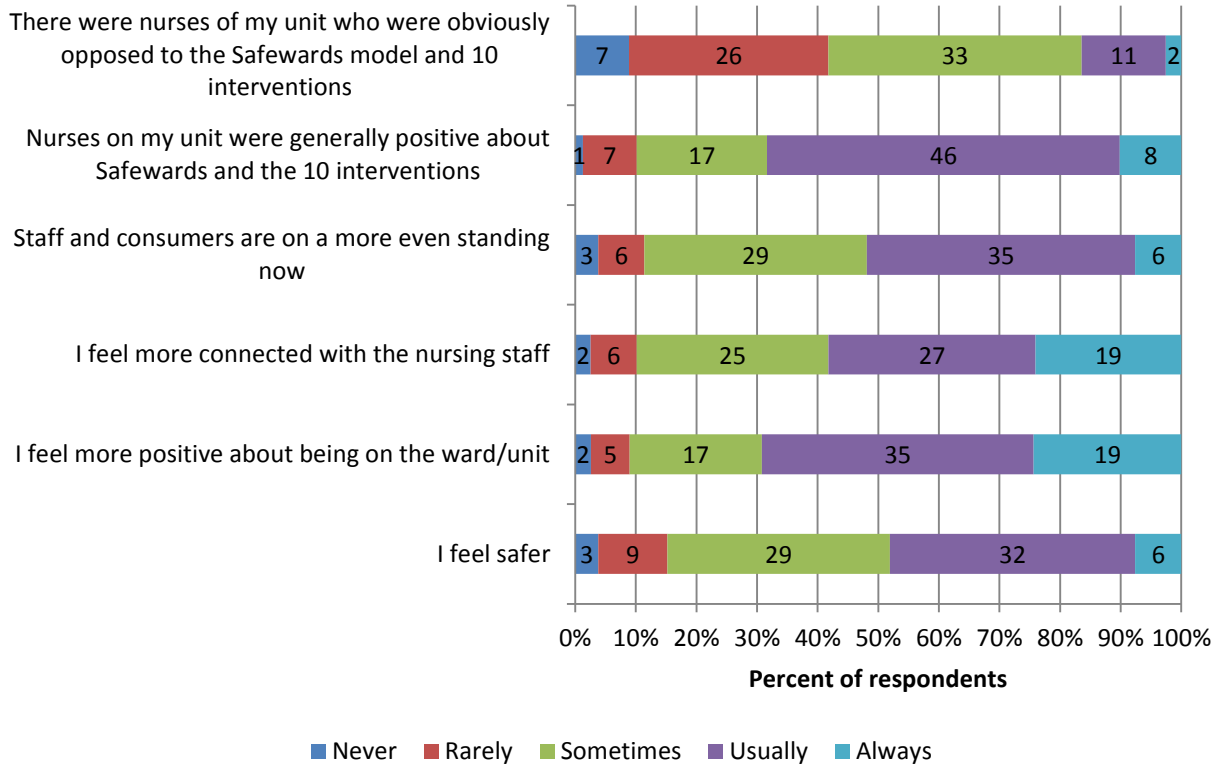


Figure 7.5 Staff perceptions of their ward/unit after the introduction of Safewards

Staff report that colleagues were not too negative about Safewards. Around 70% report that usually or always their colleagues were positive about Safewards. Fifty percent of staff feel that most of the time staff and patients are more equal now, 60% of staff report feeling more connected to their colleagues usually or always. Finally 50% of staff report usually or always feeling safer on their ward after the implementation of Safewards

Analysis of staff focus groups

The four staff focus groups ranged in duration from 82 to 95 minutes, generating 5 hours and 40 minutes of audio-recorded data. These focus groups encompassed 22 staff participants, ranging in seniority from their first year of work to over thirty years experience in mental health settings. Roles included: division 2 nurses, allied health staff, shift working registered nurses, educators and managers, with a mix of 13 women and 9 men. The groups yielded rich accounts of implementation and staff experiences. They provided a strong contribution to the understanding of: what about Safewards was underway and working well; important challenges and barriers to Safewards uptake; and staff suggestions for modifying, improving and sustaining Safewards.

Safewards: What is working well?

Thinking about their most recent work in a ward, participants identified many examples of good practice in their wards. Staff across all four focus groups reflected that Safewards is strengthening and articulating what teams have valued in their work previously:

> "Our unit has always had a good relationship with its patients, but to have the resources and the direction and have it actually put into words [with Safewards] …it is just wonderful, it's become better".

Like the consumer consultant group, ward staff considered that Safewards helpfully reinforces the 'golden rule': "Treat other people, patients, the way you want to be treated".1. Staff reflected that Safewards has boosted the

patient focus for staff: “it's just motivated everyone to step up and become more involved with the patients and what might make their admission stay more pleasant”.

Staff recognised amongst themselves what consumers have also clearly said (in surveys and a focus group) about the increased respect afforded to patients:

> “We realise, remembering they are people, caring for them, and getting to know who they are and what works best for each of them has been, is really worthwhile I think. You can see the change and just being respected and all those sort of things, they [consumers] really value it I think.”

The message of improved attitudes and staff-patient interactions carried across the groups:

> “I would be staff’s approach and attitude is raised, and I only base that on … instances of complaints, …not getting as many complaints about ‘that nursing staff member was rude to me’, so that’s dropped off, along those lines.”

The visual impact of Safewards materials was notable and highlighted in comments to staff from families:

> “The ward’s a little bit more personalised, it's not so, it's not just a ward like you know with bare walls and there's actually things about the staff and it's about the consumer as well. Families come up and say ‘oh the tree looks nice’, or ‘the getting to know each other stuff is great’”.

Staff identified *know each other* profiles and *discharge messages* to be an encouragement and a talking point with families too, who have commented:

> “for them, its good to see that there’s a difference from when they get there, and everything’s stressed and horrible, to when people are going home, and have a bit more hope, … that change can happen.”

Participants also reported positive feedback from consumers:

> “We’ve actually had a patient make comment on what they notice. Now the patient observed that the staff are always willing to stop and listen to him, the staff don’t basically disrespect anyone, and he commented that ‘that’s really hard to do because a lot of the patients will disrespect you straight back’, but he said ‘you don’t lose your calm, you just keep listening’.”

SECU staff expressed confidence in the positive impact of Safewards on relationships and therefore on safety:

> “Safewards basically will give you a better nurse consumer relationship and more it will give you safer practice, the safe practice means it will reduce as I say the episodes, reduce seclusion, reduce physical or verbal assault”

Staff in youth services described a stepping up of efforts with Safewards to intervene earlier with conflict, applying more effort to avert restrictive actions like seclusion. They described themselves and others taking more time, and staff pairing up to work intensively, in potential conflict situations: “nursing people who are starting to get distressed with more that one nurse, not in a confrontation, but two people getting together with the person, just talking, using the sensory stuff.”

Participants could identify situations where staff were extending practice to manage a challenging situation:

> Staff 1: …I think in that circumstance we just kept on offering alternatives, we couldn’t provide him with what he wanted, and was pretty adamant and damaging the place to get what he wanted, but like probably after an hour to two hours of that

Staff 2: He exhausted himself

Staff 1: Well he did but he took up options of alternatives and actually later on apologised before we actually finished our shift.

Across all groups there was a strong affirmation of the model itself:

> "Even the people who have been most resistant to certain interventions, they are not resistant to the whole ethos behind it. They might argue with a certain element of it, be it posters on the wall, language, but nobody has argued against the philosophy."

Wins with specific interventions

Participants were confident about the soundness of some interventions. *Discharge messages* displays were readily established in all the wards by the time of the FGs, an attractive ward feature.

> "We have actually implemented *positive words* in our handover, between the psychiatrists as well and the nurses, *discharge messages* we bring up every day, and through our morning meetings that we have."

Some participants commented on ways they were honing use of DM, to include encouraging messages: "We were discussing discharge messages [in a community group] and I was saying, it doesn't have to be when you're actually leaving, it can be sooner".

Participants talked about the increasing success with *calm down*: "most people are quite astounded at what's in the chill box, and they like the idea and they do take the idea, an item, with them [when they leave]." In one unit the staff said the use of sensory modulation training and the *calm down* resources in Safewards has together increased "the tools available to everyone, to cope with issues or emotions". Others reported a change in everyday approach, with staff now ask consumers: "What are you wanting to do right now, what would help you calm down?"

Participants from some wards described regular revising work with consumers, regarding *clear mutual expectations*, when new clients were admitted and as a way of bringing people into the space and establishing mutuality.

The use of sensory strategies was already prominent in aged care and Safewards affirmed their value:

> "using *calm down* and sensory equipment to avoid the use of PRN medication, that's one of the things I really like about implementing the model is that we can make those connections, it has a real flow on effect for the other stuff we do.

Participants identified how use of *calm down* is featured in the clinical file and how success is therefore reinforced:

> "when we do use a sensory or calm down strategy, it gets documented in the person's file, so what was the circumstance of using it, who initiated it, how did it work, did it prevent a more restrictive intervention sort of thing".

Staff commented that some intervention had added benefits, beyond the intended ones. For example, they described how consumers appreciated some Safewards visual displays intended for staff:

> "In our [high dependency area] there's a big poster on *talk down* methods and the other day one of our patients she was going around with, you know asking for photocopies of the poster because she said that's different from other places that she's stayed."

Other interventions, such as *know each other*, took longer to establish: "a lot of patients, well, we had requested everyone to put their profiles on the wall and most of them were resistant to do it, and we got 2 ladies they came

over and they volunteered themselves." In this case, the willingness of a few clients to contribute a profile got the processes moving, and in other wards a few staff completing profiles got the community underway.

Participants identified that there was less resistance to the model, and to interventions like KEO, if the trainers acknowledged what was similar existing practice: "like *knowing each other*, we used to do that back in the 80s you know, we used to talk to our patients about oh, I ride a motorbike, do all those sorts of things, and that's how you'd establish rapport." After which another participant said:

> "Yeah exactly, and I mean the way [our educator] did deliver it was about acknowledging people who've been around that length of time and we're not telling you how to suck eggs here, we realise you've done this before."

Commonly the experience with KEO was very positive, once the intervention was underway:

> "so our consumers love knowing about the staff, every morning we put a photo up of who's in charge, and what staff are on, so everyone's aware of who's who, so it's not just a name on a piece of paper, and they're quite receptive to that".

Some staff spoke of the positive impact of *mutual help meeting:*

> "I've heard through the social worker, just about the patients participation in that, and it seems like it's a comfortable space that the patients are free to express their concerns on the ward and their needs".

Participants could identify how *soft words* raised their own awareness about language:

> "one thing I've focussed on has been instead of saying, as just an example, somebody 'refused' a shower, they 'declined' to have a shower, … because refused is quite a harsh, almost accusatory sort of word."

Barriers and challenges to implementing Safewards

There were occasions when participants' description of interventions did not align clearly with the actual interventions, in the view of interviewers. Examples were: participants referring to staff being reassuring in a broad sense, but not about reassuring consumers in relation to a conflict event; or participants referred to using positivity in general, but not in relation to expressing positive words about patients and between staff, as intended. These two interventions were often spoken of in such ways, suggesting there was still work to be done across Victorian services to explore and communicate these interventions within the model.

Across all focus groups there was a sense of time pressure in the implementation process, so that some elements were far from settled in. Participants themselves considered that many interventions could be strengthened:

> "for example with *calm down*, the sensory room having that, having more easy access to just go and have that time out and have the surrounding you know, I think that'll be so good when we get that up and running a bit more."

The absence of ward champions for particular interventions, sometimes due to roster changes, had undermined interventions. One staff member described the limited impact of interventions with under-prepared "L plate champions":

> "L plate champions, yeah that sort of thing, not really grabbing it with both hands and running with it. So that's what I'm finding at the moment, the things that are doing well, like discharge messages, positive words, calm down methods, they're the ones [where]the staff …are real champions with it."

In some instances the champion may not be well matched and this also posed a barrier:

> "I think it's important for the *soft words* champion to be soft, like to advocate for that, because on our ward that hasn't come across very well, because that person that has it, they're not very soft, like they're quite tough."

Participants suggested there are some intrinsic challenges to using consistently the Safewards strategies, in settings with rising patient acuity, which they felt was associated with increased risk and a sense of chaos and crisis: "Acuity is going up, every unit that you know you speak to, whether it's a CCU or a SECU or inpatient, community, acuity is definitely rising, and our management of risk is escalating". They suggested: "when things are really frantic, people disengage from new things" and staff would tend to revert to familiar practices.

Cultural challenges

One barrier that participants mentioned across the groups was a strong, rule-based culture, that particularly suited the personality of some staff. While routine, consistency and order were valued for ward calmness, skills in negotiation and flexibility were also required, for example to *mitigate bad news,* for *talk down* and in line with *soft words*. Some staff struggled to work with this principle:

> "some people bend the rules a little, but others will not bend the rules at all, you know they're concrete, and sometimes in a situation that you can see might escalate, it's quite hard, you sort of think well you've got to give and take a little bit sometimes you know, for a safe outcome, sometimes. But some people just will not bend that little tiny bit you know."

Staff in another unit reflected this kind of resistance came from a minority of staff:

> Interviewer: with that kind of challenge, are there particular people..?
>
> Staff member: Actually a quarter of them, yes, I'd say.

And in another unit: "For us the staff culture, the sort of inflexibility towards change in relation to *soft words*, so that's sort of negative point on our ward".

Some participants reported encountering a bluntly behavioural approach to conflict and rule breaking:

> "When I work on SECU ward the main problem what they find is…, basically some staff don't want some change in their practice. We've got clinicians… who really believe in the old concepts of mental health. I have two people in the ward believing that there should be some consequences of what the clients do."

Even where teams were doing well to develop new patterns of practice, there were challenges in keeping flexible:

> "the team seems to have established Safewards for their environment in a very particular way, but then one particular individual that I've got in mind was impacting on other people …it changes the dynamic… the staff hadn't adjusted their thinking of how they would use it for this guy.

Participants felt that, amongst experienced staff, that when new approaches such as Safewards are introduced, there was resistance related to feeling patronised or not recognised for their skills. This was evident when "there is a fair amount of sarcasm, especially when the ward is really, really busy". The feeling was that "As we go through that wave of business, some of the new stuff sticks and some doesn't. So sensory modulation sticks, some of Safewards will stick."

Operational challenges

Practically speaking, there were challenges to keeping the momentum with Safewards. One leaders commented: "potentially a negative thing about Safewards, to me operationally it is about maintaining the training, can we, will

we? Concerns arose regarding places where wards are being rebuilt, expanding and with new staff: “when we go to the new building, the staff should triple thereby dissolving or spreading, maybe spreading what we’ve got.”

On a daily basis, practice could be undermined by operating with casual staff who did not know Safewards:

> “if you have a shortage of staff you … it's not going to be consistent to implement Safewards as it's supposed to be, and if there is some urgency or casual staff there, you have to introduce all those things, …so the approach is not going to be consistent”.

The cumulative pressures that staff experienced, for example at times of high acuity or staff shortage, added to the degree of difficulty for staff using the Safewards interventions:

> “depending on staff being stressed and overworked and staffing problems, people obviously react differently under pressure. So *soft words,* personally I don’t think it has come along very well in our ward”.

Talking immediately after the trial period, focus group participants expressed concern that there may not be people and resources enough for maintaining Safewards: “what’ll disappear? the money, key people who put in energy?” Preparing to face this same challenge, another participant reported: “we’ve actually started up a group of 5 staff members who are going to drive Safewards in the future, and so they’ll be making sure it actually runs efficiently [after the trial].”

Suggestions for modifying, improving and sustaining Safewards

Several sites were optimistic about the momentum for Safewards into the future: “it's going to look like such a natural part of the establishment that you won't even really think something different has happened here, it’ll be I can see the culture change because I’ve got the comparison of the 3 units, so particularly at SECU it's going to be a part of what they do, so I think it's going to be a self-sustaining engine”.

Staff described developments already underway that would extend and supplement aspects of Safewards: “soon we will have a sensory room”.

All groups were eager to embed and sustain the Safewards changes. Across all groups advice was that:

- implementation in any other wards should be staged, to allow firm uptake of some interventions before moving to the next
- refresher training will be essential, in the form of small scale local packages and integration into safety training
- more than one champion was required for each intervention.

Adaptions

Staff reflected that there might be a need to change aspects of the interventions and displays at intervals, in order to keep the experience engaging for people: “I wonder whether …its noticed initially and then it is part of the furniture later. So whether it needs to change to keep the focus on it, to keep up the interest of clients, and staff.”

In regard to *soft words* posters, in particular, there were concerns from staff across several wards about the expression: “The language isn’t the kind of everyday language used in Australia, …so some of them kind of had to be tweaked.” For staff in a youth ward there was overall good alignment with Safewards, which complemented the existing program and approach. However, their minor obstacle was the use of terms in the model and language in the resources: “they use containment in a very different way, and so language was one of the main hurdles for them.” The teams spent time modifying resources to better fit the language of staff and clients.

Participants encouraged each other to adapt the interventions to match the patient group or the existing strengths of the ward, increasing local ownership: “like add your own little bit flavour to the strategies”. Examples were the *mutual help meeting* known as ‘coffee on the couch’ and *calm down* tools called the ‘chill box’. Participants

described the way they built on existing routines to embed Safewards interventions: "Like the *mutual help meeting* we already had a … meeting that would happen every day and it just needed tweaking really to open up some doors".

Some adaptions were more substantial, related to distinctive features of models of care and length of stay, in wards such as SECU and aged care units. Discharge messages could benefit from adapting for SECU: "when we implemented it and the patients were hoping that if you put a discharge message you'll be discharged, so we had to [think about the wording]," Staff referring instead to 'messages of encouragement'. When consumers in aged care experienced major cognitive challenges, the *know each other* profiles were not written by them, and the staff posters were largely valued by visiting family members. Also in aged care settings the sensory strategies were well developed and even more important, when talking interventions might not fit a consumer's capacities. A wider array of sensory modulation resources were added to the calm down tools, including bubble blowing kits, tactile aprons and a range of soft and warm objects for holding.

Ways of supporting Safewards

As they planned for sustaining Safewards, participants were looking to other services for ideas and motivation: "resourcing from other units, like for example the discharge trees, seeing photos of what other people have, or coming and visiting another place".

Some had experience of the community of practice and thought it was a key support:

> "On a broad scale from my point of view the community of practice is really important, it touches on something you said about sharing information and seeing someone else's pictures. Remember with that *talk down* being removed from the staff room, we couldn't find it that day, it had been moved, and patients were looking at it? That came from one of the trainers attending a community of practice and hearing that another place had it up in a pubic space. So I think community of practice as far as Safewards goes is quite important, seeing what other people are doing well or bad."

One group discussed the champion role in detail, noting some mistakes that were made in the rush to implement:

> "when they were allocating the champions some people weren't at work that day, some people were on annual leave, so staff were just writing, allocating people, like delegating this person can be this champion. So people weren't really able to choose the role that they wanted, and fitting their personality or passion".

The group concluded that ward based leadership was essential for sustaining Safewards:

> "I think it's something that as a team we need to all get together and choose a champion [role] that we really want to do, and we can do it with 100% of you know of ourselves, and definitely yeah be respectful of that".

Drawing in the staff who have been reluctant: "in the future basically we want more staff to participate in the Safewards thing and we want to change the whole ward, like we need the whole staff participation." One recommendation was to ensure the training in core concepts reached the mass of staff:

> "the concept of Safewards needs to come first, and you've got to get your staff on board, you will always have your detractors within it, so the overall concept should be presented. And that may take some time to do that, you need more than one off sessions."

Some services had already developed ways of keeping interventions resourced, such as topping up the *calm down* box with soothing activities, including colouring materials: "staff have actually bought a lot of stuff in, …and I think it'll be replenished, we've been building on it, but getting free resources, donated too".

Dealing with resistance

Many participants had direct experience of implementing change including Safewards and their advice was to move not too quickly, but steadily: “baby steps, you’ll get less resistance with baby steps, and some of the people who object to the fast change won't even know it's happened”.

Participants reflected on how they might use their skills to see the source of resistance for an individual, work with that:

> “there's always people that do more than others, and I think that’s with any change there's always people that have an energy and want to bring good to a place, and then there's the same people that need that reminder or prompt. But I think that you’ve got to sometimes put them in a position where the change will be positive for them”

Another participant added:

> “I think people have boundaries up you know, they’ve got this, their protective armour on when they come in to work and you know, and I think that sometimes adding, giving a little bit of yourself with respect to personalising what we do … like showing people how to be more personable”.

Others reflected on the value of continuing to model an intervention, such as *positive words*, rather than confronting staff resistance: “Osmosis, just wear them down, eventually they’ll say something positive [during handover].” They described winning over staff by example.

Staff across service types were asked what would be their advice to those who are yet to work with Safewards. Participants gave strong messages about leadership and taking time. An educator’s advice was:

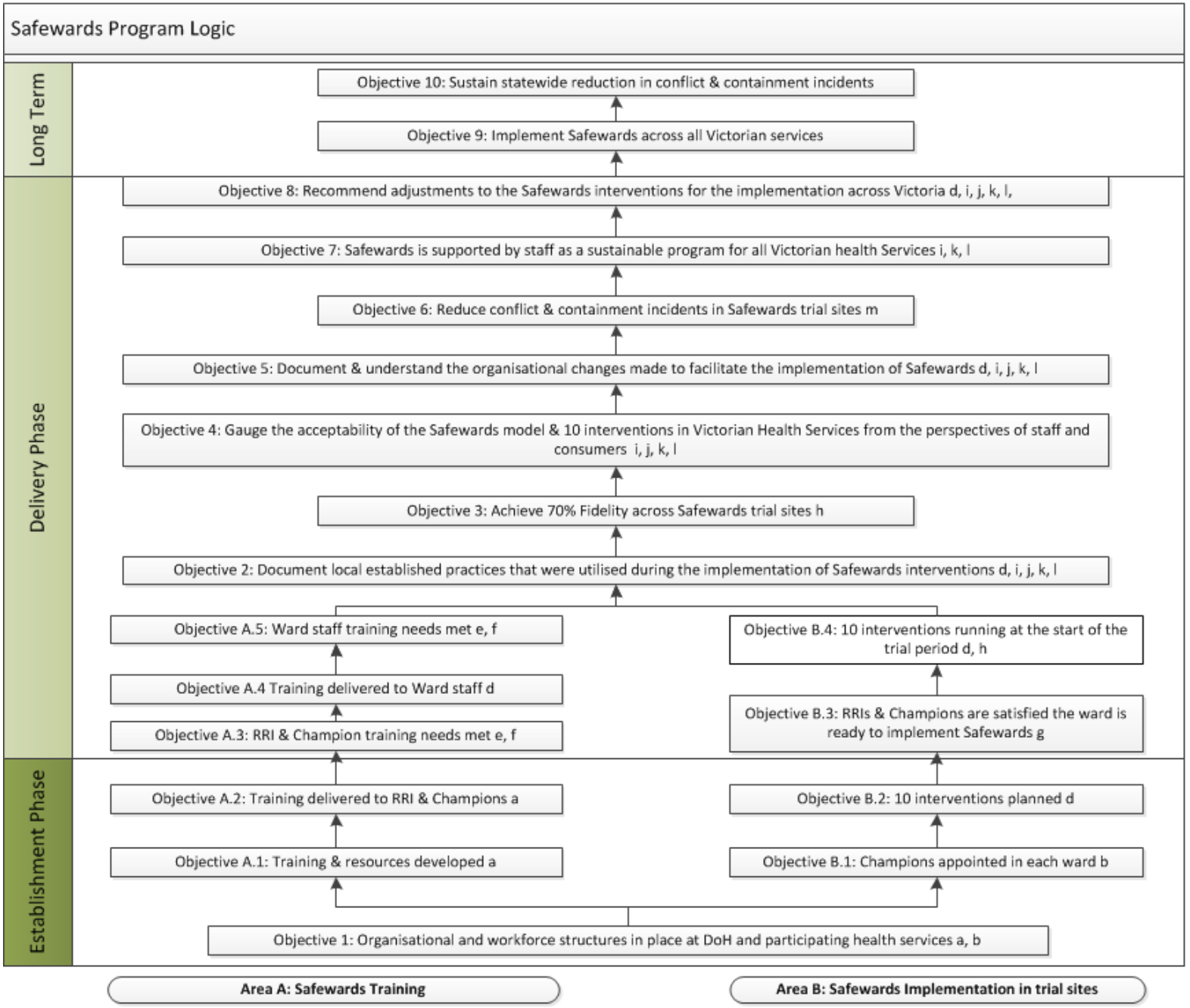
> “You’ve got to have your manager to be the leader of it, and is committed to it and shows that – then all staff will follow on the unit if you’ve got a leader to it. And then you need to pick out some people you know are really going to be running with it.” Following on, the next person in the group said: “I think definitely the consistency, I think it's something that you know will work if everyone does it, but if there's not consistency there it's not really going to work.”

A shift-leader advised:

> “Mine would be - give it a chance. Give Safewards a chance because it will help you, regardless of whether you do or don’t like certain interventions, there's something about Safewards that will fit your mould if you give it a go. Because safety is the very first issue for everybody concerned.”

Chapter 8 Program Logic: Reporting against objectives

This chapter models the findings back to the program logic that was devised at the project outset.
(see the program logic diagram on the following page)



Evaluation Components

a. Department of Health documentation
b. Summary of Safewards preparations per site
c .Evaluation plan per site
d. Implementation Diary
e. pre training staff survey
f. post training staff survey
g. readiness checklist (adjust for survey monkey)
h. Fidelity checklist (adjust for survey monkey)
i. post implementation staff survey
j. post implementation consumer survey
k. Staff focus group
l. Consumer consultant focus group
m. CMI Routinely collected statewide data

Objective 1 Organisational and workforce structures in place at DoH and participating health services

Achieved

Contracts were established between services and DHHS, defining respective obligations and structures to support this

Area A. Safewards training

Objective A.1: Training & resources developed *Achieved*

The Department contracted the services of trainers to develop the train-the-trainer package. This included compiling the information documents from the UK site (www.safewards.net/). As well as developing power point presentations with information and activities related to the Safewards model and 10 interventions.

Objective A.2: Training delivered to RRI & Champions *Achieved*

The trainers delivered the train-the-trainer package to groups of staff from each participating health service over 3 one-day training sessions.

Objective A.3: RRI & Champion training needs met *Achieved*

The post training surveys, specifically for the train-the-trainer workshops, were completed by 29 staff (a response rate of approximately 50%), 55% of these staff attended all three training days. The results reveal that staff reported all components of the train-the-trainer sessions as either 'good' or 'very good'. Thus they were satisfied with the train-the-trainer sessions, written materials, videos, interactive group activities, power point slides, the clarity of the trainers, group discussions, the time allowed for implementation planning and the degree to which their questions were answered to their satisfaction.

Objective A.4 Training delivered to Ward *Achieved*

Nurse educators and RRI Leads delivered training to their ward staff, across all seven health services. Data for the post-training surveys indicated that the ward training was different in each service and that no service delivered training in the exact format as the train-the-trainer sessions. The most common approaches reported were: formal lecture format; short in-service; interactive workshop; one to one training; and self-directed learning. The majority of staff report attending either whole day training or sessions of one hour or less (43% and 42% respectively). Seventy-three percent of respondents reported attending 1 – 3 training events, the remaining 27% attend between 4 – 11+ events. The diversity in practice makes it possible only to identify that training was delivered.

Objective A.5: Ward staff training needs met *Achieved*

In spite of diverse approaches staff across sites made significant gains in knowledge, confidence and motivation to use Safewards, through the training and implementation processes. The Safewards model and interventions were found to be acceptable to staff, as indicated by particularly heightened levels of motivation & intention to use, post-training.

Area B: Safewards implementation in trial sites

Objective B.1: Champions appointed in each ward *Achieved*

During February, prior to the start of the trial phase in March, Safewards Leads completed the Safewards readiness checklist. This revealed that 16 wards had appointed champions for 7 or more interventions. The remaining wards had appointed 3 and 6 champions.

Objective B.2: 10 interventions planned *Achieved*

The fidelity checklist revealed that just prior to the start of the trial, around 55% of wards were prepared to start delivering between 7 – 10 interventions. The remaining wards had planned the implementation of 3 – 6 interventions at this point.

Objective B.3: RRIs & Champions are satisfied the ward is ready to implement Safewards *Achieved*

No data directly accounts for this objective, however all services did commence implementation.

Objective B.4: 10 interventions running at the start of the trial period *Partially Achieved*

The fidelity checklist was completed by the researchers at each site within the first two weeks of the trial and the results showed that wards were implementing between 0 – 8 interventions at the start of the trial.

Objective 2: Document local established practices that were utilised during the implementation of Safewards interventions *Achieved*

All sites completed a diary of implementation process

Objective 3: Achieve 70% Fidelity across Safewards trial sites *Partially Achieved*

The fidelity checklist conducted by researchers in the final 2 weeks of the trial phase revealed that some wards but not all had implemented 7 or more interventions, i.e. achieved 70% fidelity. Five of the 10 adult wards were implementing 7+ interventions and seven out of eight adolescent/youth, aged and SECU wards were implementing 7+ interventions. Thus 67% of wards had achieved at least 70% fidelity.

Objective 4: Gauge the acceptability of the Safewards model & 10 interventions in Victorian Health Services from the perspectives of staff, consumers and carers *Achieved*

Triangulated survey and focus group data shows a high level of acceptability of Safewards for consumers, consumer consultants and staff.

Objective 5: Document & understand the organisational changes made to facilitate the implementation of Safewards *Achieved*

Triangulated data from diaries and staff surveys show how organisations made changes to implement Safewards

Objective 6: Reduce conflict & containment incidents in Safewards trial sites *Partially Achieved*

Seclusion data does not show a reduction in the containment strategy; but staff and consumers surveys and focus groups indicate reduced conflict.

Objective 7: Safewards is supported by staff as a sustainable program for all Victorian health Services *Achieved*

There is sound support from consumers and staff for embedding Safewards into practice.

Objective 8: Recommend adjustments to the Safewards interventions for the implementation across Victoria *Achieved*

Outcome data and staff and consumer feedback inform recommendations for adaption.

Objective 9: Implement Safewards across all Victorian services *Beyond the scope of the current project*

Objective 10: Sustain statewide reduction in conflict & containment incidents *Beyond the scope of the current project*

Chapter 9 Discussion & conclusions

This chapter primarily discusses the findings that are reported in Chapters 5 to 7. It focuses on outcomes and impacts, applicability, acceptability and sustainability of Safewards, drawing together the lessons from all qualitative and quantitative findings across the phases of the trial and follow up. The Victorian Safewards Trial findings are considered in the practical context of state policy and with reference to key literature. Outcomes and effectiveness in this evaluation are considered in terms of use of seclusion associated with Trial implementation and impacts are discussed in terms of consumer and staff experience of Safewards.

The aim of the Safewards model and interventions is to reduce conflict events in inpatient units, and thereby also to reduce use of containment or restrictive practices, such as seclusion. Safewards identifies that staff in inpatient wards can act on a range of flashpoints that may otherwise progress to conflict and containment events. Thus rates of both conflict and containment can be considered outcomes of Safewards. **The seclusion rate** is one important indicator of 'containment' or restrictive practices, therefore analysed before and after Safewards implementation and in comparison with other Victorian services. Victorian outcomes are discussed with reference to the previous Safewards research that used seclusion as the measure of containment.

Seclusion use was identified as a primary outcome measure of effectiveness in this study for two main reasons: 1) seclusion rates were reported for the experimental study of Safewards in the UK (Bowers *et al* 2015), enabling comparison with Victorian performance; and 2) seclusion rates already function locally as an indicator of containment practices, because seclusion events have been routinely and reliably reported for almost a decade in Victoria (Chief Psychiatrist 2016). A metric of seclusion events per 1000 occupied bed day is a standard key performance indicator for clinical services.

Conflict is the other key outcomes featured in the Safewards model, but reliable and routine measures of conflict are lacking. The Safewards RCT suffered from low rates of completion of the conflict measure, the Patient-Staff Conflict Checklist (PCC) (Bowers *et al* 2015). No measure of conflict could be feasibly proposed for the Victorian Safewards Trial. Instead, experiences of conflict were investigated through consumer and staff report, at the end of the trial.

Consumer experiences and views of Safewards are important markers of outcome and impact. The consumer experience findings are discussed in light of the intentions and claims made for the Safewards model and interventions. Staff experiences of working with Safewards round out the discussion of impact, for this final report of the project.

In 2014 a new Mental Health Act in Victoria drew greater attention to the need to uphold people's human rights and to minimise restriction of freedoms. The Victorian Safewards Trial was undertaken at a time when all inpatient units were also designing and implementing initiatives to reduce restrictive interventions. Thus the non-Safewards wards were not engaged in 'business as usual', with regard to seclusion use in Victorian wards.

This discussion of the outcome evaluation is situated within an integrated discussion of the overall evaluation findings, tied back to the questions set for the project. The chapter is therefore structured in sections of: **Evaluation of Effectiveness and Impact**; **Evaluation of Applicability and Acceptability**; and **Evaluation of the Implementation Process and Sustainability**. Based on this integrated discussion of findings, the chapter concludes with recommendations for future Safewards implementation and evaluation in Victoria.

Evaluation of effectiveness & impact

The effectiveness of Safewards was originally demonstrated via a cluster RCT, which showed Safewards to be effective in reducing conflict events and also in reducing the use of seclusion in acute adult inpatient units in England. The Victorian Safewards Trial likewise aimed to reduce conflict and use of restrictive interventions, such as seclusion. The Victorian trial was also undertaken with the wider aim of impacting positively on the experience for consumers and staff in inpatient units.

Seclusion outcomes

Eighteen wards were included in the Safewards intervention group, and pre- and post- seclusion rates were related to all admissions and all patients across the intervention sites, for two discrete three-month periods of December 2014 to February 2015 inclusive, and then June to August 2015. In a sustainability development of the project, a further follow up period was established for analysis as December 2015-February 2016 inclusive.

Use of seclusion pre- and post- Safewards trial

In the 18 inpatient wards trialling Safewards across seven Mental Health Services in Victoria we found no significant difference in seclusion event rates in the immediate post-Safewards period, compared to the baseline period (pre = 11.67, post = 12.26, p=0.76). The seclusion rate changes for the 18 wards between time periods was also compared with the seclusion rate changes for all non-Safewards units in the same time periods, and there was no significant difference between groups.

Use of seclusion in the follow up period

Further analysis was conducted to compare seclusion rates pre- Safewards with a time period in the sustainability phase of the project: December 2015 to February 2016 inclusive. This time period allowed for consolidation in use of Safewards, and has the added advantage of matching the pre-Safewards period in the annual cycle, accommodating any seasonal variation. Safewards showed a non-significant reduction in seclusion rates in the 18 wards from pre Safewards to follow-up (pre = 11.67, to follow-up = 7.511, p= 0.19). Non-Safewards units showed an increase in seclusion rates in the same period, but the differences between Safewards and non-Safewards wards overall was not found to be statistically significant.

Looking at the seclusion rates for the different service types in the pre- and follow up period, the youth/adolescent ward type showed a significant reduction in seclusions between the pre-Safewards period and the follow up period and this differed from the slight increase in seclusion the non-Safewards units (Safewards seclusions change score = -10.35, a marked reduction, versus non-Safewards change = +0.86, a slight increase, p=0.01)

These seclusion rate findings overall contrast with the experimental evidence, where Safewards was associated with a statistically significant 26.4% reduction in use of seclusion, as reported in a cluster RCT of Safewards in 31 acute adult units in the UK (Bowers *et al* 2015). The reduction differed significantly from seclusion rates in control units (95% CI 9.9–34.3%). An area of effective change in seclusion rates for the Victorian Safewards Trial was youth/adolescent wards, where Safewards units better than halved their seclusion rates (-10.35 events per occ beddays, CI 3.08-19.33, p=0.01) by follow up, and this was a significantly better rate than non-Safewards youth wards, where seclusions increased.

The conclusion drawn is that **Safewards was not robustly associated with reduction of seclusion, as the chosen measure of containment, but there are indications of a seclusion reduction trend across the Safewards wards, by the follow up time-point.**

The staff and consumer reports of reduced conflict, confirmed in both qualitative and survey reports, are also very encouraging indications that Safewards had a positive impact on key outcomes. Further monitoring of outcomes in Safewards wards is highly desirable, as this finding that Safewards reduces conflict requires systematic confirmation. There would be considerable value in finding a way to measure conflict events in wards using Safewards. Some researchers have begun to look at the use of handheld devices, to increase ease and accuracy of reporting of verbal and physical aggression events, in the dynamic setting of inpatient nursing work (Iennaco, Dixon, Whittemore & Bowers 2013).

In addition to these outcomes, we have shown that Safewards improved many aspects of practice and experience, from the consumer and staff perspective.

Factors related to Safewards' effect on seclusion

Experienced mental health staff in participating sites and across the state suggested some factors that may have contributed to notably higher levels of seclusion in general, in the year of the Trial: illicit drugs available and high reported community usage during the trial period, may have impacted patient acuity and presentations; and high ward occupancy and short lengths of stay in all Victorian wards may have worked against reducing seclusion rates.

In terms of particular challenges for the Safewards sites: even higher ward occupancy in Safewards wards may have worked against Safewards impacting seclusion rates. The 'opt in' (ie not random) sample for the Victorian Safewards Trial may in fact have been biased to include wards that came to the project with established pattern of higher seclusion rates than was the case for the non-Safewards services. A range of drivers for such a sample bias would then undermine straightforward comparison of Safewards wards with non-Safewards wards. Further analysis, beyond the scope of this project, might identify factors that drive the wide variation in seclusion rates across Victorian wards.

Impact of Safewards for consumers

While the effect on seclusion was equivocal, the impact and experience of the Safewards trial for consumers and staff was significant.

Consumers reported feeling safer in wards since Safewards and more optimistic during an inpatient stay. The range of highly positive qualitative and quantitative survey responses from consumers are important, in light of the equivocal quantitative outcomes in regard to Safewards impact on containment.

Consumers were confident that Safewards had reduced verbal conflict. More than half of consumers surveyed also considered that it had reduced physical conflict. This finding comes from a consumer survey question: "Has Safewards helped to reduce the level of the following incidents in your unit? Verbal conflict, physical conflict, absconding, property damage." In the absence of comprehensive event data about conflict, the survey question is important for an understanding of consumer perceptions of Safewards' effectiveness.

Consumers Consultants and peer workers highly valued Safewards in principle and in practice. They identified that **Safewards in practice positively influences a culture of respect for consumers, enhancing mutual respect, openness and information sharing in wards**.

These findings round out a picture of considerable practice change by staff in wards, changes that were highly valued by consumers. The other notable change identified was in consumers own behaviour. Consumers were supported by Safewards initiatives to respond differently, in a more supportive and respectful way, to each other and to staff. Staff also identified the increased emphasis on respectful communications that accompanied Safewards interventions.

No research to date has reported the perspectives of consumers or carers regarding the impact of Safewards. Studies of consumer experiences in inpatient settings in Australia and internationally show consumers are mainly: appreciative of listening and support when provided by nurses; valuing of engagement in group programs; and critical of restrictive practices (Wood & Alsawy 2016, Molin, Graneheim & Lindgren, 2016). Recommendations for service improvement often include increasing the quality and amount of staff-inpatient communication (NICE UK 2011, DoH Victoria 2013). The experiences of staff and consumers show that Safewards makes a positive contribution into these priority areas.

Evaluation of applicability and acceptability

Beyond the overall affirmation of Safewards and its impact, consumers and staff had clear messages to convey about details of Safewards, including the most valued elements and some recommended adjustments.

Consumers' experiences with Safewards in Victoria

Consumers who directly experienced Safewards were overall clearly in favour of the Safewards initiative and of several individual interventions which required considerable consumer action for success. They valued in particular the *mutual help meeting*, *know each other, discharge messages* and *clear mutual expectations*. Consumers also described in detail changes in staff practices that they valued, regarding such interventions as *talk down* and *soft words*. Consumers clearly identified an increase in staff attitude of respect accompanying the implementation of Safewards. Consumers identified and illustrated with examples practice changes such as: staff listening more to consumers; and staff more skilfully delivering bad news.

The *mutual help meeting* was overwhelmingly experienced as a positive initiative, enabling and enhancing consumers' own inclination to provide mutual support. Informal, mutual support between inpatient peers is a phenomenon that is recently gaining attention (Bouchard *et al* 2010). The feedback from Consumer Consultants and peer workers mirrored the feedback from consumers who were directly experiencing Safewards in inpatient units. The importance of the concept of mutuality was expanded on and tied to other opportunities for input, for consumer workers to champion and teach Safewards. Consumers and Consumer Consultants were strongly in favour of continuing and supporting Safewards in inpatient settings. Consumer consultants also recommended explicit information/ communication about the model to consumers and carers.

A minority of consumers expressed misgivings about Safewards. Most of these referred to misuse of Safewards interventions, such a staff telling people to 'calm down' or the actual use of *talk down* being limited, whereby the consumer saw that the staff approach to conflict still resulted in prn medications and restrictive interventions. Some consumers experienced *calm down* tools as patronising or the *know each other* profiles as intrusive. Consumers were more often curious to know more about the model, and were eager to know about interventions such as *talk down*.

Overall, both consumers and staff identified an increased experience of respectful interactions and safety and empowerment.

Staff experiences with Safewards

Participants in surveys and focus groups gave clear message that Safewards was highly acceptable to them. Many staff readily described their understanding of the model, affirmed its fit with important everyday work, illustrating how it applied in practice.

In surveys, staff overwhelmingly reported using all ten interventions 'often' or 'always'. In each of the four staff focus groups, participants affirmed that Safewards had positively contributed to their work, often by validating and reinforcing good practice. In addition, they identified a change in themselves and their own practice, as they were using Safewards. The change they described was typically having a more positive attitude and utilizing more positive language than they had in the past. Staff described how Safewards increased a sense of permission for staff to take time with such important work as constructive self-disclosure, use of sensory interventions, skillful de-escalation and preparing for sharing bad news. These are some of the intended impacts of the model and interventions (Bowers 2014).

The staff participants in the evaluation activities cannot be seen to reflect the views of all staff in those sites. The evaluation methods were strong, the sample for surveys is sound at 23% and the four staff focus groups captured a diverse group of staff, in terms of education and years of experience. However, engagement in these evaluation activities required participant effort, so staff sample overall is assumed to be positively biased towards Safewards. Furthermore, all respondents described other colleagues as being less invested than themselves in Safewards, and as resistant to some interventions. Consumers and staff reported that attitudes of staff worked as both enablers and barriers to Safewards.

Descriptions and explanations of negative attitudes regarding Safewards included:

- Lack of willingness to disclose about themselves (such as in *know each other* or *mutual help meeting*)
- Lack of trust towards consumers (regarding the scope for mutuality in keeping *clear mutual expectations*)
- Fear of aggression (if negotiating more in *talk down*, versus arranging for restraint)
- Fear of being held responsible if others are harmed (as above)
- Fear of being taken advantage of (such as in *soft words*, saying yes)
- Feeling unfairly blamed for aggression (challenging the model re staff contribution to flashpoints)

Applicability of Safewards to new areas

The inclusion of inpatient wards for adolescents and youths and aged persons' and also SECUs extended the implementation of Safewards beyond its original target group. As a group, these extended settings achieved higher fidelity across the trial period and in the sustainability period than the group of acute adult wards. In the focus group discussions, staff from all settings overwhelmingly supported the applicability of the Safewards model for the setting and consumer population.

The adolescent and youth services achieved high fidelity on average, though this varied across the three units. The ready uptake was enabled by: high staff-patient ratios, readily adapted service models and group therapy programs, and high interpersonal and therapeutic skill levels among staff. Particular challenges were the sometimes high level of arousal and distress in the units, with chaotic and high energy behaviour. Staff also reported a crowded program of therapeutic activity and staff training (such as 'sensory modulation' implementation overlapping with Safewards training), that led to some staff fatigue and lack of interest in Safewards. The lessons learned from implementation in these units are important for determining the scope for Safewards in Victoria in the future. These lessons are also of particular interest to the originators of Safewards in the UK.

After initial delay, the participating SECU wards achieved high fidelity. The SECU teams reflected in the focus group that this service type presented particular opportunities for Safewards to flourish. For example, the *know each other* intervention, with its aim to form congenial relationships, was powerful for people who experienced a long inpatient stay in the unit. Once underway, such an intervention could be capitalised on in conversations about common interests and the information could be refined over time. The unhurried routine in the SECU wards provided time and opportunity for more experimenting and discussion about the use of *calm down* resources. Barriers in this setting included a stronger reliance among some staff on asserting behavioural rules, and that type of interpersonal approach was challenged by *soft words* and *clear mutual expectations*.

The aged units achieved the lowest fidelity across service types, pointing to significant adaptions that might best apply to aged mental health care settings. In the long-stay aged unit, *discharge messages* were adapted as encouraging messages, mainly from family members. The cognitive demands of writing and talking in interventions such as *mutual help meetings* were not reasonable for many consumers in long-stay aged unit, so adaptions were under consideration. Staff in the focus group identified as a barrier the idea that some staff held lower expectations than warranted, about consumers' capacity. Staff reported the high benefits of *soft words,* including the focus on tone of voice and non-verbal communications, and they considered that Safewards had extended the use of *calm down* resources.

Evaluation of the implementation process and sustainability

Implementation of Safewards in the Victorian Safewards Trial consisted of establishing site level projects, with staged change processes and identified change agents ('Safewards Leads') across seven organisations, whose work was supported by a systematic training effort. Following the major implementation effort in the trial phase, local services then devised processes to support and sustain Safewards. Communications between services was assisted though a Community of Practice, seeded by the Department of Health and Human Services.

Training, enablers and barriers to implementation and fidelity

The training approach represented a considerable investment in Safewards training for Victoria. At least 414 staff participated in structured Safewards training in Victoria, comprised of a mixture of didactic and multimedia sessions, facilitated workshops, brief presentations within wards and individual coaching. Training was scheduled to occur in a distinct and compact timeframe over a four month period. Participation of staff in training events ranged from 1- 10 events and from 1 to 24+ hours. In pre-training surveys, most participants reported having undertaken pre-reading and having some baseline knowledge of the model and interventions.

This training package approach contrasted with the off-the-shelf and self-managed approach that is promoted in UK, and is enabled via the Safewards website and webinar supports. There is no existing research yet available regarding training for Safewards. Analysing the effectiveness of the Victorian Safewards training was an important evaluation task for the project. Since Safewards is currently being implemented in many services in Australia and across the world, the training approach and resources generated in Victoria will be of interest nationally and internationally. The previous report in September 2015 provided detailed analysis of the training and implementation processes. The key messages are summarised below.

Training key points

The Victorian Safewards training approach was effective for preparing staff across Trial sites.

- The majority of staff (414+) across sites participated in central and/or local Safewards training
- Staff made significant gains in knowledge, confidence and motivation to use Safewards, through the training and implementation processes
- Central train-the-trainer workshops were highly valued by participants
- Train-the-trainer delivery - from central workshops to local delivery - gave rise to highly diverse local Safewards training delivery modes, ranging from one day events to 10 minute sessions around handovers
- Services could be confident that their staff who engaged in any Safewards training gained knowledge, confidence, motivation and intentions that were important for using Safewards.
- Integration of data from surveys, checklists and diaries provided strong data to explore and explain findings

Training survey results indicated the most valued aspects that should be retained in future training:

- Clear presentation of the model, concepts and interventions
- Time to clarify questions regarding the model and interventions
- Time to discuss local implementation of the intervention
- Small group activities regarding *know each other, discharge messages*
- Many of the resources were highly valued and translated into local training situations. On that basis we conclude that central materials are worth reviewing, the local adapted materials warrant gathering up, ready for future distribution in any further Safewards training.

Additional findings from feedback surveys and focus groups in the follow-up stage suggest three more conclusions:

- Scheduled training programs are required for new staff, and should be broadened to consumer workers and medical staff
- Training will be critical where new facilities are being commissioned and teams are substantially expanding
- Leaders should redress misapplication of interventions that suggest gaps in knowledge: e.g. *reassurance, positive words* were commonly referred to as *being positive* or *reassuring*, but without any reference to the core intervention
- Orientation training is also required for casual staff and administrative support staff in inpatient units

A well-known barrier to practice change in hospitals is services failing to provide opportunities for a critical mass of inpatient staff to attend training, due to cost or unavailability of replacement staff (McCann & Bowers 2005). This challenge must be addressed, as services will need to commit to ongoing training in order to sustain Safewards.

Implementation key points

Services took different approaches to the roll-out of the 10 interventions, including to staging and timing of interventions, the appointment of champions and any promotional activities. Their reports match the growing evidence base for what works in translational or implementation science (see for example Grol, Eccles & Davis 2013). The recent interest in recognising consumer roles and in building consumer workforce to enhance consumer experience of inpatient care is well supported by these evaluation findings. In particular, this evaluation affirms recent work to articulate the importance of consumers providing mutual support. The study by Bouchard et al (2010) provides a useful resource for policy makers and staff in mental health services, to enhance this informally occurring peer support amongst inpatients, a feature that is both intended and evident, in this evaluation of Safewards.

Well evidenced approaches to implementation that were successful in the Victorian Safewards Trial included:

1) weaving the interventions into current structures – such as *mutual help meetings* integrated with daily group program
2) gaining multidisciplinary buy-in and teamwork contributing to implementation, especially where an intervention was well matched to existing roles
3) senior level engagement in the project – such as executives leading by example, to produce and share a *know each other* profile
4) nominating existing grass roots leaders in roles such as intervention champions, to model practices, coach others and shape opinions (Grol *et al* 2013).

Local processes were associated with a range of enablers and barriers

- Engagement of staff at many levels of the organisation impacted upon implementation
- Engagement of a leader and key group of staff inside the wards that were positive and supportive of the Safewards model facilitated implementation
- Engagement of opinion-leading, shift-working staff, since interventions depend on shift-working nurses
- Operational constraints to implementation in the Trial period included tight timeframes for training and implementation, operational barriers to purchasing items

Additional findings in the follow up period suggests this added conclusion:

- Consumers in inpatient wards were commonly invested in mutual support but their role was not well recognised in training or implementation processes, as enablers of Safewards
- Positive staff attitude is needed specifically for staff to i) begin the practice change, to ii) rely less on rigid rules and to iii) increase quality and time spent in staff-patient interactions, with the intent of preventing conflict.

Fidelity key points

Implementation success was shown in the very good standard of fidelity achieved over time. The previous report provided detail about fidelity gains in the trial. This report adds detail about fidelity growing steadily in the sustainability period.

- Fidelity increased across all but 3 wards across the Trial period of three months
- Fidelity was not consistent for the multiple wards that were part of a single organisation, with shared senior staff and training across those wards. This supports the conclusion that effective implementation was achieved locally, within the ward itself, through people, routines and activities in the ward.

- From wards with low fidelity or slow implementation, we learned that practice change could not be achieved if these wards lacked or lost people in critical roles.
- Common issues were i) not enough implementers present on the ward site, ii) implementers lacking operational power, or iii) active resistance from others with operational power.
- Fidelity increase further for all 14 monitored wards over the sustainability period of 9 months, despite minimal further investment in personnel or training
- The pattern of growing fidelity over time suggests that some interventions were more readily implemented (such as *soft words* and *talk down*), others took time to set up or establish in the setting (such as *calm down* and *clear mutual expectations*) and still other interventions may have commenced later but become well embedded, with a high degree of consumer support (such as *mutual help meeting* and *know each other*).

The Safewards Victorian Trial achieved a higher level of success in implementation than the UK experimental study of Safewards, as shown through measurement of fidelity (Bowers *et al* 2015). Aside from the structured training effort, there were similarities and differences in the implementation process used for the Victorian Trial compared with the experimental study (Bowers *et al* 2015). The Victorian project involved a longer preparation phase for leaders and staff, and the UK trial involved more frequent visits and ad hoc training, from a project implementation team. Fidelity was measured in the experimental trial and wards achieved a score of less than 50% fidelity on average across the trial period. The fidelity was measured in the Victorian Safewards Trial using the same tool and fidelity was found to be considerably higher at 67%, including in the service types that were not part of the UK trial.

Sustainability of Safewards

The previously reported process evaluation included preliminary recommendations about ingredients for effective implementation of Safewards in other wards in Victoria. More than a year on from the commencement of the Safewards Victoria Trial, this evaluation adds rich detail to the picture of what was required for effective implementation, and additionally what is required to sustain Safewards.

Sustained Fidelity

Findings show Safewards can be sustained in Victorian wards

- Independent fidelity monitoring provides clear evidence that Safewards is sustained and stronger, achieving 90% fidelity at the 12 month point after the Trial commenced.
- Monitored wards grew in fidelity post trial, through a time when key staff roles were not sustained and no extra funds were attached to further implementation
- There was variation in average fidelity over the whole year, whereby individual wards and service types showed different fidelity trajectories.

There are no studies yet with which we can compare Victoria's performance in sustaining Safewards. This situation may change, given the increasing number of Safewards implementation projects occurring internationally, across services and jurisdictions. The fidelity achieved in the Victorian Safewards Trail is laudable, both during the trial phase and at follow-up, because multifaceted psychosocial interventions that require team participation are notoriously difficult to implement, and total fidelity or high fidelity is rarely achieved (Nelson *et al* 2012).

Ongoing drivers, facilitators and resources

The findings from follow-up surveys and focus groups highlighted previously under-regarded drivers and facilitators of local and sustained implementation. These can be harnessed to strengthen future implementation and sustaining of Safewards.

- Consumers were often drivers of prominent interventions: *mutual help meetings, discharge messages, calm down*

- Some elements were well supported by existing group programs, at best providing a pathway to embedding interventions
- Allied health were drivers of several successful interventions, *mutual help meetings* and *calm down*, but staff were less aware of them than consumers were
- The involvement of shift-working nurses was essential for some interventions: *positive words, bad news mitigation, talk down, know each other*
- Embedding was enabled when attention was paid to the way Safewards complements existing work e.g. with sensory modulation and therapeutic program models

The importance of Safewards resources was also highlighted in the survey and focus group data. This specific feedback about resources can inform a local Safewards maintenance plan:

- Visual elements of Safewards are valued, will need regular refreshing
- Consumer Consultants identified positive value of Safewards visual displays for consumers and carers: *clear mutual expectations*, *discharge messages* and also the *talk down* posters.
- Staff identified the value of revisiting content, e.g. for *clear mutual expectations* and *soft words* so people keep engaging with the meaning
- Local refresher sessions could include both training and a resource updating activity
- Innovations for restocking *calm down* resources include seeking donations
- Consumers in several wards are being assisted to source or buy *calm down* resources, to take home

Ongoing barriers and support needs

Combined commitment of key executive and senior ward staff to implementation was most commonly associated with early and sustained fidelity. Though fidelity was very high overall at follow-up, in surveys and focus groups staff and consumers continued to identify barriers to Safewards thriving in their settings. Service types also faced somewhat different barriers: crises and chaos intermittently undermined practice in youth services and to some extent adult wards; rigidity of rules and low expectations of consumers could impede interventions in aged and SECU. Organisation-based leaders needed to attend to local barriers.

Ongoing processes are required to address barriers to the sound, sustained use of Safewards, such as these reported in the follow up period in surveys and focus groups:

- A minority of staff in every service resisted engaging in the interventions
- Experienced staff resisted, if existing skills were not acknowledged
- Levels of Safewards trained staff decreased, as staff turned over
- Casualised workforce undermined interventions

Findings about ongoing challenges give rise to added conclusions about ongoing support needs:

- The community of practice (CoP) is valued and accessed by people with key ongoing roles: educators, allied health, Clinical Nurse Specialists
- The same core group of leaders have accessed international supports, such as the Safewards Facebook group and the UK-based webinars
- The CoP and other linkages between services can support sharing of information resources, adaptions in training and strategies for addressing barriers
- However, the CoP is not accessible to shift working staff, including those staff that are vital as champions and role models
- Provision of targeted support is required to enable the effective role of shift working champions of Safewards

The evaluation has been comprehensive and wide-ranging, yet evaluators identified a range of questions that extend beyond this evaluation and more ideas and activity associated with Victorian Safewards Trial that warrant exploring:

- Elements of evaluation should continue, as local and state level quality activities: ie continuing fidelity and outcome monitoring and analysis
- Sustained evaluation will require local drivers and also an overarching program or between-service linkages
- To investigate further the effectiveness of Safewards, evaluation could explore added metrics of seclusion duration, monitoring other restrictive practices such as use of *pro re nata* (prn) intramuscular injections
- Local and state level stakeholders should consider how to measure conflict, the missing piece in Victorian evaluation of Safewards
- Follow up evaluation of adaptions is warranted, including for new service types – forensic, emergency MH

Future new implementation of Safewards

The overall growth in fidelity, from an average of four interventions underway in the beginning of the trial to seven by the trial end, to nine by follow up period end demonstrated that staff and most organisations could not 'do Safewards' from day 1, but that most wards continued to improve their implementation achievements. All service types experienced implementation time frame as too short, recommended staging over six months to get all interventions underway. The findings suggest there is more intrinsic momentum for Safewards, once underway, than is commonly found in other change programs in inpatient settings.

Consumer consultants drew attention to the level of influence inpatient consumers themselves have in reducing conflict and improving interactions, between consumers and with staff. They recommended investing in consumer champions for interventions, consumer co-trainers for the model, consumers to usually chair mutual help meeting, …etc

Limitations

Evaluating Fidelity

Fidelity of Safewards implementation was an important element of the evaluation, and the use of the existing fidelity checklist for measurement enabled comparison of fidelity achieved in the Victorian Safewards Trial with that reported within the randomised controlled research of Safewards. Notwithstanding that it is a well justified element within this evaluation design, the Safewards fidelity checklist is somewhat limited as measure of fidelity.

A design limitation of this evaluation tool is the binary ratings (ie the intervention is present/absent) of several items: *positive words, soft words, mutual expectations* and *bad news mitigation*, based in some cases on such evidence as posters displayed in the ward. This rating approach contrasts with the scaled ratings of other items, notably: *know each other, mutual help meeting, discharge messages* and *calm down*, that incorporate counts of occasions of use. Binary ratings of fidelity are limiting, because they provide a crude measure of implementation of a psychosocial intervention. It is possible that implementation is over-rated for some items, such as *soft words*. The checklist was applied in accordance with use in the UK trial, in order to enable comparison of the Victorian Safewards fidelity outcomes with the published experimental trial.

Furthermore, the inter-rater reliability of fidelity checklists was not established in the previous UK trial and has not been evaluated in this project. Members of the research team individually visited different wards to complete the checklists. The researchers discussed their observations and findings after time one ratings were completed. This may have assisted inter-rater agreement for subsequent time points. Rater bias may have impacted on validity especially at time two, when service staff completed fidelity checklist for their own wards. A research recommendation arising from this evaluation is that the fidelity measure warrants careful revision, with the aim of strengthening it for use in ongoing Safewards monitoring, locally and internationally.

Evaluating primary outcomes

The measurement of outcomes is a critical feature of evaluation. The use of seclusion events for key standardised quantitative data used as the primary outcome is well justified in the Safewards evaluation project, but it presents a limitation for the evaluation. The model aims to reduce conflict events as well as to reduce reliance on containment measures, such as seclusion. However no routine or existing quantitative data was identified as useful for the purpose of measuring conflict events.

The lack of a measure of conflict was a constraint on the evaluation, given the central place of conflict events in the model. Conflict rate, as identified using the Patient–Staff Conflict Checklist (PCC) was a second important outcome measure, were important in past evidence of Safewards effectiveness (Bowers *et al* 2015). The decision not to build this measure into the Victorian Safewards Trial evaluation project was based on concerns about adding burden to inpatient staff workload, a known risk from past evidence of poor PCC completion.

The re-consideration and/or development of a measure of conflict is the subject of another research recommendation.

Recommendations from the Victorian Safewards Trial evaluation project

Integration of the findings from this evaluation brings together evidence of the full range of inputs, processes and outcomes that matter for all stakeholders. Out of these findings comes a list of empirically supported key ingredients, and a refined model, for future implementation of Safewards.

Recommendations for policy and governance

1. **Further implementation of Safewards should be supported in Victoria,** with the overarching aim of increasing safety

The objective of further implementation are to i) extend the identified benefits of Safewards for the safe experience of those in ward environments ward, both consumers and staff; and to ii) improve communications and relationships among consumer and staff; and to iii) *potentially* contribute to reduction of restrictive interventions in inpatient wards.

2. **A reliable and feasible measure of conflict should be identified, for routine use** in inpatient wards

The objectives of this action are to i) increase understanding of conflict as a key issue for staff and consumer safety and to ii) support ongoing monitoring of Safewards.

Recommendations for future Safewards implementation processes

3. **Proposals for Safewards implementation should include the people, knowledge and support elements** featured here:

People

→Senior organisational buy in initially & intermittent engagement through a year, to attend to implementation barriers

→At least 2 mid-level change agents present in the ward, including: educator/s, a person with operational authority (e.g. Nurse Unit Manager, Associate Nurse Unit Manager)

→A consumer consultant/peer worker, active with one or more interventions

→At least one of: an allied health staff member or medical staff member active with one or more interventions

→Intervention champions appointed, present & active on the ward (number is not determined) until intervention is embedded

Knowledge

→Strong understanding of the model & the interventions within the change agents

→Clear understanding of key concepts in the model within majority (>50%) of ward based staff, new and casual staff inducted/oriented to model & interventions

→Knowledge of the model and aims among consumers and carers

→Explicit processes for adaption of training materials, prepared trainers

→Local knowledge of outcome data, regarding conflict & containment

Functional Support

→Training resources, schedule to train (& potentially test) knowledge at intervals

→a plan to fit training with existing mandatory schedule

→Dedicated budget for intervention items, plan for replenishing

→Explicit processes for considering adaption & fit of interventions with existing ward space, practices, documents, daily & weekly routines, policies

→ Safewards integrated into quality review, including KPIs,
a timeframe & identified agent for fidelity monitoring & feedback

→Organisational link to another Safewards site

This model can be further refined with key personnel at current Safewards sites, and used as a resource to implement Safewards in other wards and sites.

Conclusion

The results of the Victorian Safewards Trial evaluation provide a multifaceted account of the outcome and impact of Safewards on the practice of staff and the experience of consumers in inpatient wards.

The outcome of the trial does not neatly align with the existing evidence, that Safewards reduces the restrictive practice of seclusion. However, the research evidence from the experimental study is still compelling, since randomised controlled research produces stronger research evidence than the pre-post evaluation study design. Furthermore, the seclusion trend (a statistically non-significant reduction), and the sub-group analysis (significant reduction for youth wards), supports a conclusion that Safewards shows potential to reduce restrictive practices in Victoria.

The high level of fidelity with the Safewards intervention, sustained over a year is a major finding of the evaluation. The quantitative finding, that fidelity increased steadily in the months after an intensive intervention phase, is not common in studies of practice change (Grol, Eccles & Davis 2013). This reinforces the qualitative findings that staff and consumers found Safewards feasible and valuable. The findings of positive impact and high acceptability should drive further implementation of Safewards in Victoria.

The high fidelity at follow up also highlights the impact of training activities and implementation strategies on the uptake of Safewards model and interventions, across a variety of inpatient wards, up to April 2016. The lessons learned regarding training and implementation and outcomes will be of relevance and value to many other inpatient services in Victoria, Australia and internationally.

The ongoing and increasing fidelity that was achieved, beyond the time frame of funding for project and key roles, supports the Safewards Victorian Trial approach, investing time and effort in early training and implementation of Safewards, for effective and sustainable implementation. Services can be confident that Safewards is a sustainable intervention of value across the spectrum of Victorian inpatient settings.

References

Bouchard, L., Montreuil, M., & Gros, C., (2010). Peer support among inpatients in an adult mental health setting. *Issues in Mental Health Nursing*, 31(9): 589-598. doi: 10.3109/01612841003793049

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing* **21**(6): 499-508. doi: 10.1111/jpm.12129

Bowers, L., Stewart, D., Papadopoulos, C., & Iennaco, J. D. (2013). Correlation between levels of conflict and containment on acute psychiatric wards: the city-128 study. *Psychiatric Services*, 64(5), 423-430. doi:10.1176/appi.ps.201200328

Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal Of Nursing Studies,* 52(9): 1412-1422. doi: 10.1016/j.ijnurstu.2015.05.001

Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology, Qualitative research in psychology, 3:2 77-101. doi: 10.1191/1478088706qp063oa

Chief Psychiatrist, Victoria. (2016) *Chief Psychiatrist's annual report 2014-2015*, State of Victoria, Department of Health and Human Services, State Government of Victoria, Melbourne. Accessed at: https://www2.health.vic.gov.au/about/publications/annualreports/chief-psychiatrists-annual-report-2014-15

Department of Health, Victoria. (2013). *Nursing observation through engagement in psychiatric inpatient care: Department of Health guideline.* Mental Health, Drugs and Regions Division, Department of Health, Victorian Government, Melbourne. Accessed at: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Nursing%20observation%20through%20engagement%20in%20psychiatric%20inpatient%20care

Gillham, B (2000). *Developing a Questionnaire.* Continuum, London

Grol, RMW., Eccles, M. & Davis, D. (2013). *Improving Patient Care: The Implementation of Change in Health Care, Second Edition*. doi:10.1002/9781118525975

Hamilton, B., & Love, A. (2010). Reducing reliance on seclusion in acute psychiatry. *Australian Nursing Journal*, 18(3), 43.

Happell, B., Bennetts, W., Tohotoa, J., Platania-Phung, C., & Wynaden, D. (2016). Nothing without vision! The views of consumers and mental health nurses about consumer involvement in mental health nursing education. *Collegian, 23*(2), 241-248. doi: http://dx.doi.org/10.1016/j.colegn.2015.04.004

Iennaco, J., Dixon, J., Whittemore, R., Bowers, L. (2013). Measurement and Monitoring of Health Care Worker Aggression Exposure. *The Online Journal of Issues in Nursing* 18(1), January 31 2013, 3. doi: 10.3912/OJIN.Vol18No01Man03

McCann, E., & Bowers, L. (2005). Training in cognitive behavioural interventions on acute psychiatric inpatient wards. *Journal of Psychiatric and Mental Health Nursing*, 12(2), 215-222. doi: 10.1111/j.1365-2850.2004.00822.x

McKenna, B., Furness, T., Dhital, D., Park, M., & Connally, F. (2014) The transformation from custodial to recovery-oriented care: A paradigm shift that needed to happen*. Journal of Forensic Nursing.* 10(4), 226-233. doi:10.1097/JFN.0000000000000045.

Molin, J., Graneheim U.H., & Lindgren, B-M. (2016). Quality of interactions influences everyday life in psychiatric inpatient care-patients' perspectives. *International Journal of Qualitative Studies on Health and Well-being,* [S.l.], v. 11, jan. 2016. ISSN 1748-2631. Available at: <http://www.ijqhw.net/index.php/qhw/article/view/29897>. doi:http://dx.doi.org/10.3402/qhw.v11.29897.

Nelson, M. C., Cordray, D. S., Hulleman, C. S., Darrow, C. L., & Sommer, E. C. (2012). A procedure for assessing intervention fidelity in experiments testing educational and behavioral interventions. *Journal of Behavioral Health Services Research*, 39(4), 374-396. doi: 10.1007/s11414-012-9295-x

National Institute for Health and Clinical Excellence UK (NICE UK). (2011). Quality standard [QS14]: Service user experience in adult mental health services. December 2011. Accessed at: https://www.nice.org.uk/Guidance/QS14

Schoenwald, S., Garland, A., Chapman, J., Frazier, S., Sheidow, A., & Southam-Gerow, M. (2011). Toward the effective and efficient measurement of implementation fidelity. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(1), 32-43. doi: 10.1007/s10488-010-0321-0

Wood, L., & Alsawy, S. (2016). Patient experiences of psychiatric inpatient care: a systematic review of qualitative evidence. *Journal of Psychiatric Intensive Care*, 12(1), 35-43. doi: 10.20299/jpi.2016.001