

# Building a Safe, Therapeutic Milieu on an Adult Inpatient Psychiatric Unit through Structured Nursing Interventions: Evidence-Based Practice

JANET LEE, MSN CANDIDATE, FULD FELLOW; MARLENE MEYER, RN-BC, BSN; TERRY EDMUNDSON, RN, MScN, NURSE MANAGER

JOHNS HOPKINS UNIVERSITY SCHOOL OF NURSING AND JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

**1 Background**  
Inpatient psychiatric unit violence results from the complex interactions among the patient, staff, and culture of the specific unit (Hamrin, V., Iennaco, J., & Olsen, D., 2009). Successful de-escalation was preceded by fewer, less aggressive, conflict events, pared with unsuccessful de-escalation, such as administration of medications (Lavelle, M. et al, 2016).

Safewards is an evidenced-based model of care designed to **reduce conflict** (patient behaviors that can result in harm, such as aggression, rule breaking, self-harm, or attempts to elope) and **containment** (restrictive or coercive methods staff use to control difficult behavior on the unit, such as emergency medications, constant observation, security detail, restraint, and seclusion). The Safewards model identifies ten interventions aimed to reduce both (Bowers, L., et al (2015).

**2 Objectives**

- Identify and implement evidence-based strategies to maintain a safe, therapeutic milieu
- Since violence is a relatively rare occurrence on this unit, goals would be set to maintain or reduce these rates and maximize patients' engagement in recovery and satisfaction with care

**3 Methods**  
After a comprehensive literature review on evidence-based strategies, we selected to pilot the Safewards program, a bundle of ten interventions to be phased in over the year. Measures involve collecting baseline data, a shift checklist, and intermittent surveys of staff knowledge, skills, attitudes, and barriers. Methods varied by implementation of the intervention.

With the launch of our first intervention, Soft Words, we also introduced the "Mid-Shift Huddle Milieu Checklist" which was to be filled out by the rounding nurse daily. Some adjustments were made to make the checklist more concise, taking less than 3 minutes to fill out.

SAFEWARDS INTERVENTIONS	
<b>Bad news mitigation:</b>	When confronted with distressing news from family, friends, or the treatment team, difficult patient behavior can escalate. This initiative helps proactively identify and mobilize psychological and social support, before distress becomes a flashpoint.
<b>Calm down methods:</b>	By reinforcing a patient's own coping mechanisms to self-soothe, this intervention provides a menu of easily accessible items (hot/cold packs, stress balls, music, scents, warm beverages, etc.) to reduce arousal and support patients to contain overwhelming emotions.
<b>Clear mutual expectations:</b>	Uses published expectations and group work to discuss unit norms; helps contain difficult behavior by reinforcing structure, consistency, and engaging patients and staff in making changes to improve safety and satisfaction.
<b>Community meeting:</b>	Template to better ensure the consistent use of a wrap-up meeting at the end of the day; forum to review progress toward goals, discuss unit news and expectations, express appreciation, and use games to promote socialization, humor, and gestures of kindness.
<b>Discharge messages:</b>	Engages soon-to-be-discharged patients in displaying written messages on what was helpful and what they liked about the unit; reinforces gains made and taps into patients' altruistic needs to share hopefulness about treatment and recovery with new patients.
<b>Know each other:</b>	Just as it is important for staff to know a patient's background, it helps patients to know something about staff, including therapeutic self-disclosure of innocuous personal information. Connection builds empathy and makes de-escalation efforts more effective.
<b>Positive words:</b>	Engages staff in reflecting what is going well and/or something likeable about each patient at handoff. When not possible, noticing something positive about the way staff supported one another in providing care to a difficult patient helps build camaraderie.
<b>Reassurance meeting:</b>	A debriefing meeting held with patients to address behavioral emergencies; allows patients to emotionally process unexpected, potentially frightening public incidents and receive support and reassurance from staff.
<b>Soft words:</b>	Short statements posted in the nursing station, changed weekly; intended to broaden staff skills and options during potential flashpoints: saying "no" to a patient, asking a patient to stop a behavior, or asking a patient to do something he/she may not want to do.
<b>Talk down/de-escalation:</b>	Short statements posted in the nursing station, changed weekly; intended to broaden staff skills and options during potential flashpoints: saying "no" to a patient, asking a patient to stop a behavior, or asking a patient to do something he/she may not want to do.

## 4 Preliminary Results

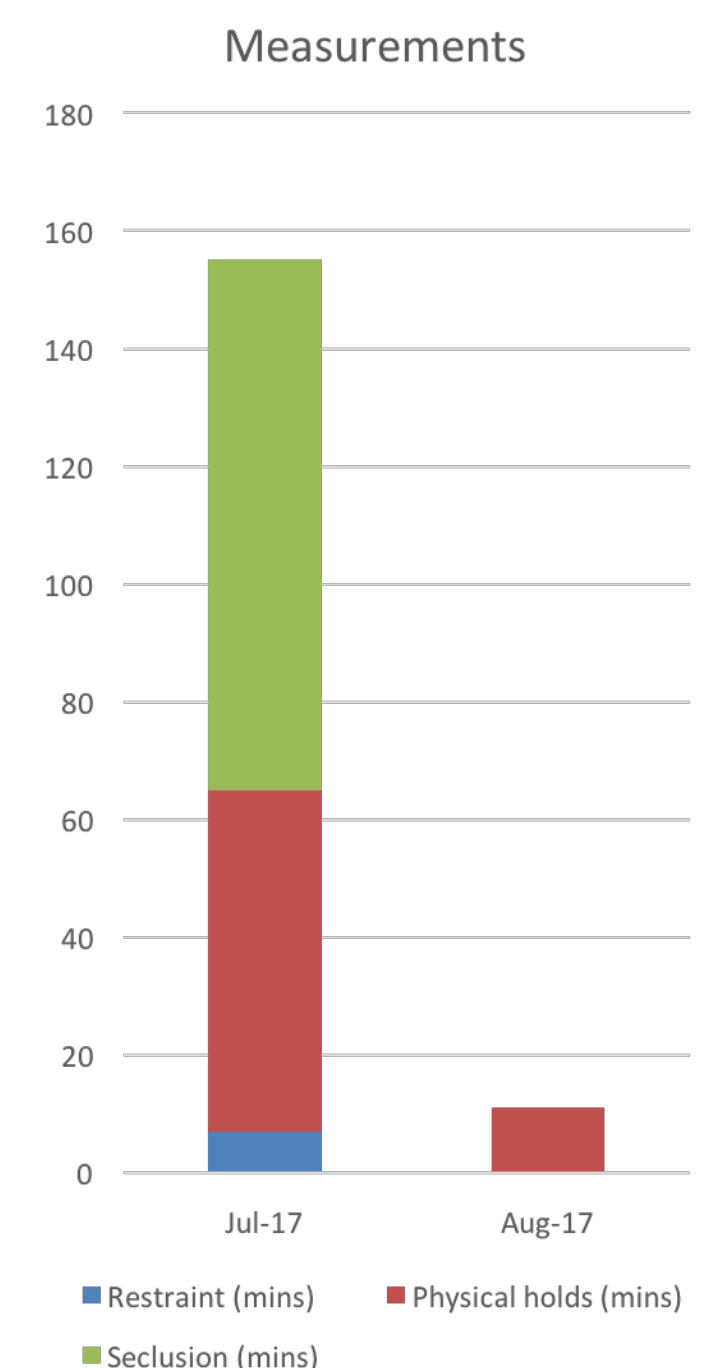
### Establishing baseline:

**July 2017:**

- 7 min: restraints
- 58 min: physical holds
- 90 min: seclusion
- 574 patient days
- Rate = 0.1875**

**August 2017:**

- 0 min: restraint
- 11 min: physical hold
- 0 min: seclusion
- 571 patient days
- Rate = 0.0133**



Baseline measures: seclusion and restraint rates (total restraint minutes + physical hold minutes + seclusion minutes per 1000 patient hours).

**Goal: ≤1.3/1000 pt hrs.**

## 5 Future Directions

As this project was at the beginning stages, no conclusions were able to be drawn. Based off the successes of Safewards Interventions, we would anticipate similar results.

Many studies on containment and therapeutic relationships in the psychiatric setting has been conducted in the United Kingdom. At the conclusion of this project, it would be recommended that other acute psychiatric floors join in on weaving in interventions with their patients and documenting results.

## 6 References

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Figure 1. Safewards Intervention methods