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Medical and surgical nurses' experiences of modifying and implementing contextually suitable Safewards interventions into medical and surgical hospital wards

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Abstract

Aim: To explore general nurses' experiences of modifying and implementing contextually suitable Safewards interventions into medical and surgical hospital wards.

Design: Qualitative action research was used working with nurses as co-researchers.

Methods: Pre-implementation focus groups were conducted in April 2022 to understand and explore the current strategies nurses utilized to avert, respond to or decrease violence. Following this, two Safewards interventions were modified by the nurses on the wards. Post-implementation focus groups were conducted in October 2022, to explore the nurses' experience of implementing Safewards interventions and the effect on their nursing practice. Data were analysed using Braun and Clarke's framework for thematic analysis.

Results: Three themes emerged from the analysis of the pre-implementation focus groups that reflected the type of violence experienced by these nurses and the context within which they occurred: 'the space is hectic'; 'it can feel like a battlefield'; and 'the aftermath'. These themes encompass the nurses' experience of violence from patients and their visitors. Following the implementation of two modified Safewards interventions, the analysis of the focus groups reflected a change in nursing skills to avert or respond to violence: 'Safewards in action'; 'empathy and self-reflection'; and 'moving forward'.

Conclusion: Safewards interventions can be successfully modified and used in general hospital wards and influence nursing practice to manage patient and visitor violence.

Implications for the Profession: In the interests of safety, successful interventions to reduce violence towards general hospital nurses should be a priority for managers and healthcare organizations. Averting, mitigating and managing violence can decrease the negative professional and personal effect on nurses and ultimately improve well-being, job satisfaction and retention rates. Furthermore, decreasing violence or aggressive incidents leads to a safer patient experience and decreased number of nursing errors ultimately improving patient experiences and outcomes.

Understanding nurses' experiences of violence and working with them to explore and develop contextually relevant solutions increases their capacity to respond to and avert violent incidents. Contextually modified Safewards interventions offer one such solution and potentially has wider implications for healthcare settings beyond the specific wards studied.

Impact:

- This study addressed the implementation of modified Safewards strategies in medical and surgical wards to prevent violence.
- Three themes emerged from the analysis of the pre-implementation focus groups that reflected the type of violence experienced by these nurses and the context within which they occurred.
- Following the implementation of two modified Safewards interventions, the post-implementation focus groups reported positive changes to their practices using the modified resources to prevent violence from patients and their visitors.
- Mental health interventions, such as those used in the Safewards model can be modified and provide a tool kit of interventions that can be used by medical and surgical nurses.

Reporting Method: This paper has adhered to the COREQ guidelines.

Patient or Public Contribution: No patient or public contribution.

What Does this Paper Contribute to the wider Global Clinical Community?

- This paper outlines and discusses the action research approach undertaken to work with general hospital nurses to modify mental health nurses' Safewards interventions into their clinical practice.
- This paper provides evidence of the 'real world' application of Safewards interventions by medical and surgical nurses in general hospital wards.
- This paper presents qualitative findings based on focus group methods to highlight the narratives of general nurses and their experiences of violence.

KEYWORDS
action research, focus groups, medical nursing, qualitative approaches, surgical nursing, workplace violence

1 | INTRODUCTION

The World Health Organization defines violence as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation' (World Health Organization, 2023).

There is a plethora of literature reporting on violence towards nurses (Chazel et al., 2023; Liu et al., 2022), yet it remains a worldwide problem including Australian hospitals with one study reporting that two thirds of Australian nurses surveyed ($n = 4891$) had experienced violence in the preceding year (Shea et al., 2017). Despite this, incidents are often underreported, and the true prevalence is likely much higher (Babiarczyk et al., 2020). Nurses make up the largest proportion of healthcare workers and are considered most vulnerable due to the nature and characteristics of the work environment.

Workplace violence against nurses may vary with emergency and mental health departments having the highest rates and has been the subject of extensive international research (Hahn et al., 2013). It is well-reported that patients, with their family, present to the emergency department (ED) with physical and psychosocial issues that may contribute to violence. In the ED, most patients are not only acutely ill or injured but can also present with social and psychological issues, mental health conditions or alcohol/substance use, intoxication or withdrawal, which may increase the risk of violence (Bingöl & İnce, 2021). Many are subsequently admitted into hospital wards where they remain at an elevated risk of violence. Additionally, patient visitors may be concerned and anxious, overzealous to support their family members or have other risks for violence. Therefore, medical and surgical nurses contend with violence from patients

and their visitors. Several strategies have been suggested and implemented to manage conflict and violent situations within the hospital setting, particularly in the ED and mental health settings (Morphet et al., 2018).

Workplace violence increases nursing staff levels of stress, reduces mental and physical well-being and job satisfaction, ultimately contributing to decreased retention and potentially negative patient outcomes (Havaei & MacPhee, 2020). Despite this, there has been limited exploration of medical and surgical nurses' experiences of violence and its prevention and it is timely to consider preventive interventions and strategies in general hospital ward settings. Given that patients and relatives are the most common perpetrators of violence (Babiarczyk et al., 2020), the implementation of effective prevention programs to decrease violence is essential to decrease the negative personal and professional outcomes. Considerable advances in violence prevention interventions have been made in mental health inpatient settings and could be transferable to medical and surgical contexts. One such strategy is the Safewards toolbox for conflict and containment prevention (Bowers et al., 2014).

2 | BACKGROUND

Safewards is a nurse-led interventional model used in mental health nursing. The model is a theoretically grounded series of interventions for reducing conflict and containment (Table 1). It is a multi-component model consisting of 10 core interventions based on mental health nursing theory that promotes improved communication, therapeutic relationships and supportive environments. The model identifies six key domains that influence conflict and containment namely the physical environment, patient community, regulatory framework, patient characteristics, staff team and factors outside the hospital (Bowers et al., 2014).

Safewards was developed for nurses in adult acute mental health inpatient settings, however, more recently has been implemented in forensic inpatient wards, secure aged, adult and adolescent wards and facilities for the intellectually disabled locally and globally (Mullen et al., 2022). While the context, language and specialty of mental health nursing is vastly different to general nursing, the experience of verbal and physical violence is not.

TABLE 1 Safewards interventions (Safewards, 2023).

Clear mutual expectations
Soft words
Talk down
Positive words
Bad news mitigation
Know each other
Mutual help meeting
Calm down methods
Reassurance
Discharge messages

A review of the literature did not reveal any research about the implementation of Safewards in general hospital wards. Given the success of the model's use in mental health inpatient settings, it is timely to consider implementing these interventions in the general hospital ward context. The aim of this paper is to present the results following implementing two Safewards interventions into two general hospital wards.

3 | THE STUDY

3.1 | Aim

To explore general nurses' experiences of modifying and implementing contextually suitable Safewards interventions into medical and surgical hospital wards.

3.2 | Objectives

1. Work with nursing teams on two general wards to identify issues around patient and visitors' violence.
2. Introduce Safewards model and work with general ward nurses to modify contextually appropriate Safewards interventions.
3. Implement the chosen modified interventions.
4. Evaluate the process.

4 | METHODS

4.1 | Design

Participatory action research (PAR) was the methodological approach used to implement Safewards interventions into two general hospital wards. PAR is an emancipatory research design which acknowledges that participants are actively engaged in all aspects of change to make improvements in a particular setting (Titchen, 2015). It is predicated on the premise that: only the participants in a social setting can understand the way practices are conducted with shared language which has meaning to their practice; the participants can develop contextually relevant actions; and communities of practice can be developed to support positive individual and collective practice change. It is a triad of action, participation and research (Schubotz, 2020). Action research facilitates changes in practice and enables supportive relationships between the participants. Furthermore, it enables researchers to address real-life practical problems through the cycle of fact finding, planning, executing and assessing (Gray, 2020; Lewin, 1946). This aligns with the Safewards approach of think, plan, do (Safewards, 2023). The research team was directly involved with the nurses on the ward to effect change and improve clinical practice by empowering them to modify and implement Safewards interventions and improve safety. Akin to the characteristics of PAR, the nurses on the ward had a commitment to change the way they managed potential and actual violence.

4.2 | Process of PAR

Informed by Lewin (1946), the spiral of fact-finding, planning, executing and evaluation was enacted, therefore, three phases were used to implement the interventions. Phase one of the PAR involved fact-finding by collecting data to understand and explore the current strategies the nurses used to avert, respond to or decrease violence. Data were collected using pre-intervention focus groups. In line with action research principles, the planning and execution phase two commenced. Three of the co-researchers attended the wards from March to October 2022 and provided information and resourcing sessions. The team provided the nurses with the 10 original Safewards resources and facilitated ongoing collaboration to create modified resources that would be applicable to their wards (Table 1). Aligned with the work of Bowers et al. (2014), the aim was to enable the nurses to judge what interventions were most applicable to their wards. To develop rapport and provide information about the 10 Safewards intervention resources, formal and informal meetings were arranged and included meetings during handovers. There was no obligation for any nurses to attend or contribute. Posters for each intervention were also left in staff tea rooms for review. As the 10 Safewards resources are specific to the mental health context, an iterative process was used by the nurses and the research team to modify and change the resources to ensure the appropriateness of content and language to general hospital ward settings. The nurses were encouraged and supported to choose the interventions they thought most relevant and applicable to their ward context. Both wards independently chose 'Soft Words' and 'Talk Down'.

The nursing staff of both wards were presented with the ten Safewards interventions, with both independently chose 'Soft Words', and 'Talk Down'. These interventions were modified by the nursing staff to be applicable to their ward environment. Of the 40 'Soft Words' posters available in the original Safewards resources, 18 were selected for use in one ward and nine in the other and they were not altered. A new 'Soft Words' poster was displayed weekly. The second intervention 'Talk Down' poster was heavily modified by both groups of nurses to be applicable to their ward environment. Following each meeting and through ongoing feedback the researchers harnessed the nurses' ideas and suggestions and changed the wording, style and formatting of the 'Talk Down' resource. They discussed a variety of scenarios that occurred frequently within their context and prepared ways to deal with them utilizing 'Soft Words' and 'Talk Down'. The nursing staff then used the two chosen interventions in their clinical practice. This encompasses the participation aspect of the PAR process.

To complete the action research cycle and to evaluate results of the action, phase three post-intervention focus groups were used to harness information about the nurses' experience using the modified resources and the effect on their clinical practice.

4.3 | Study setting and recruitment

The Safewards interventions were implemented in two general wards in a large tertiary hospital in New South Wales, Australia in 2022. The wards had 19 and 28 beds, respectively, and employed 78 and 83 nursing staff, respectively, at the time of the study. The project was supported by the hospital and ward Nursing Management. The study was undertaken post COVID lockdowns, however, visitor restrictions and mandatory mask were still enforced. Purposive sampling was used to recruit registered nurse participants to all phases of the project. All nurses from the selected general wards were invited to participate in the project as co-researchers including the formal and informal meetings to choose and modify the interventions and the focus groups. Flyers were distributed in the staff tearoom, communication books and electronically through emails. Nurses who expressed an interest in participating were provided with participant information sheets and consent forms.

4.4 | Data collection

Fact finding (phase one) and evaluation (phase three) data were collected using semi-structured questions in the pre-implementation and post-implementation focus groups. The advantage of focus groups is the capacity to generate discussion around shared experiences, feelings and attitudes and engage the co-researchers in reflection, which is aligned with action research methodology (Gray, 2020). Sharing and listening to other nurses' experiences validates concepts, identifies collective perspectives, and can trigger ideas for participants (Katz-Buonincontro, 2022). By conducting focus groups, the research team was able to explore and describe the nurses' experiences of violence and what strategies they currently used to predict, prevent and respond to violence. In the post-implementation focus groups these concepts were re-visited and additional data regarding their experience using Safewards interventions were collected. The focus groups were led by two female registered nurses experienced in qualitative research educated to Bachelor of Nursing (Hons) and PhD and were approximately 21–43 min, with an average of 28 min in duration.

4.5 | Data analysis

The focus groups were digitally audio-recorded and were professionally transcribed verbatim. The transcripts were then compared to the audio recordings to ensure accuracy. The qualitative data from this study were analysed thematically using Braun and Clarke's approach (2006) which offers a rigorous, systematic and flexible way to abstract and report patterns, meaning and themes across data sets. It enables the inductive analyses of qualitative data to achieve a rich description and interpretation of the data. While this approach

is subjective with concerns regarding researcher bias, the authors mitigated this by following Braun and Clarke's (2021) process of reflexive thematic analysis which allowed for more deliberative and reflexive engagement.

The process began with listening to the audio recordings to ensure accurate context and meaning was reflected in transcripts. The second step involved searching the data for participant experiences that had similar meaning and developing codes. Emergent themes were compared to discover common and shared ideas which required an examination of identified themes and their relationship to each other. The qualitative software package NVivo 7.0 was used in the analysis. Thematic analysis was undertaken by two members of the research team. All data were read by both researchers who independently themed the data. The themes were discussed until consensus was reached. The themes were then returned to the wards for review. No feedback was received which reflected satisfaction of the generated themes.

4.6 | Ethical considerations

Ethics approval was provided by the relevant hospital and University Human research ethics Committees (Western Sydney University H14875 and Nepean Blue Mountains Local Health District ETH01056). All focus group participants were provided with a participant information sheet that fully explained the aims, risks, benefits and commitment inherent in participating in the focus group and was also verbally reiterated. Written voluntary informed consent was obtained from all participating nurses. Ethical considerations regarding the potential for nurses becoming distressed talking about violence were mitigated by the commitment of the interviewer to stop the focus groups should any of the nurses become distressed and that participants could leave at any time without explanation or consequence. No participants withdrew from the study. Contact details of free counselling services were provided on the information sheet for all participants. As a function of the use of focus groups to collect data, confidentiality and anonymity could not be assured, however, no identifiable information was used in the reporting of the findings.

4.7 | Rigour

Strategies were applied during planning and implementation to ensure the rigour of the focus group findings. To mitigate biased research outcomes that may occur if participants have a specific agenda (Maddison & Strang, 2018), there was prolonged participant engagement and contributions were considered throughout data analysis thus enhancing credibility. Individual biases and acknowledgment of preconceived notions were considered by the research team through self-reflection, which also allowed a more nuanced understanding of the issues. The research team individually reviewed and coded transcripts, regularly referring to the original data to confirm findings which enhanced credibility.

4.8 | Findings

From the 10 Safewards interventions, both wards independently chose 'Soft Words', and 'Talk Down'. Of the 40 'Soft Words' posters available in the original Safewards resources, 18 were selected for use in one ward and nine in the other and they were not altered. A new 'Soft Words' poster was displayed weekly. The second intervention 'Talk Down' poster was heavily modified to be applicable to their ward environment. Ongoing feedback from the nurses resulted in the 'Talk Down' poster being contextually modified. They discussed a variety of scenarios that occurred frequently within their ward environment and prepared ways to deal with them utilizing 'Soft Words' and 'Talk Down'.

4.9 | Pre-implementation focus groups

Prior to introducing the Safewards model to the nursing staff on the wards, pre-implementation focus groups were conducted in April 2022 to understand and explore the current strategies utilized to avert, respond to, or decrease violence (see Appendix S1). Six focus groups were held across the two wards involving 28 female and six male participants. Most participants were in the 21–30 age group with a range of nursing experience between <1–29 years and an average of 10 years' experience (see Table 2).

4.10 | Themes

The issue of violence against nurses in the ward was raised in most focus groups. Three themes emerged from the data relating to the risk factors, experiences, and consequences of violence; '*The space is hectic*', '*It can feel like a battlefield*', and '*The aftermath*'.

4.10.1 | The space is hectic

This theme relates to the variety of factors nurses felt were precursors to patient or visitor violence. The examples nurses gave as precursors or flashpoints to violence included poor communication, delays in response to treatment, Covid-19 visiting restrictions, unrealistic patient or visitor expectations and altered patient cognition. Poor communication concerned keeping the patients and visitors informed about clinical decisions and their future treatment, participants commented:

> Yeah, they often get angry, um, when they don't get told what's happening.
>
> (FG6)

TABLE 2 Pre-focus and post-focus group characteristics.

	Pre-focus groups		Post-focus groups	
	n	%	*n*	%
Sex				
Male	6	18	2	9
Female	28	82	20	91
Age (years)				
21–30	14	41	9	41
31–40	7	21	4	18
41–50	7	21	5	22
51–60	6	17	4	18
>60	0	0	0	0
Did not say	0	0	0	0
Employment status				
Part time	9	26	2	9
Full time	24	71	18	82
Casual	1	3	2	9
Highest qualification				
Certificate	2	6	1	5
Diploma	2	6	4	18
Post grad certificate	6	17	3	14
Post grad diploma	0	0	1	5
Bachelor	23	65	12	24
Masters	0	3	1	5
Other	1	3	0	0
Yes	19	56	16	72
No	10	29	1	5
Not sure	5	15	5	23

> And then you ask people to go talk to them and explain it to them, and then you come back for … you have a couple of days off, you come back for your shift, and they still haven't done it.
>
> (FG3)

Nurses discussed the frustrations caused by lack of communication when patients were left waiting for procedures. Often the patient was prepared for a procedure that was repeatedly cancelled. Miscommunication or lack of communication between the nurses and other members of the multidisciplinary team about these cancellations often left the nursing staff dealing with angry and aggressive patients and visitors.

> And they're usually fasting which makes them angry too.
>
> (FG3)

> Especially when their procedures are cancelled time after time after time. They can be waiting for a procedure for, you know, three days because a [procedure] or something has come in and bumped them off the list. And then the same thing might happen the next day … and, um, the medical team won't tell them. It's the … it's the nursing staff that have to go and tell them.
>
> (FG3)

The participants also noted that doctors did not have the same experience as nurses when relaying information about delays.

> And I find they're better with doctors than with us. If a doctor goes to them and says, 'Your procedure has been cancelled,' blah, blah, blah, blah, they're okay. But if we go and tell them, they get really angry. I've noticed it … like we cancelled it.
>
> (FG6)

Nurses perceived unrealistic expectations among patients including their viewpoints about the role of the nurse and the time available for their care. Sometimes this involved a sense of entitlement, where unacceptable behaviours were exhibited without consequence.

> But there's also a lot of entitled people out there … yeah … who'll say, if you don't give me what I want, I will … discharge against medical advice because I'm not going to get what I want. And if I say that, you're going to do exactly what I say.
>
> (FG3)

This was reiterated in another focus group with one participant vocal about patients' treatment of nurses … *they have these privileges, that they can just speak to nurses like we're nothing* (FG3).

Participants added that because of the hectic ward environment, it was sometimes not possible to explain everything to the patient prior to commencing their patient care.

> So things such as reading the situation, going this person looks really ticked off, maybe we should give them some space, maybe we should start a dialogue. It's very much just like abruptly, we're doing this now, we're doing that now, this is what has to happen. And like people aren't, um, objects, they don't like being treated in such a way.
>
> (FG1)

Altered cognition was also a precursor to violence described by the nurses, which included patients with dementia, delirium or those under the influence or withdrawing from substances. Resoundingly, nurses were sympathetic to patients with deliriums and dementias and recognized that their ward setting may contribute to their violence. The participants frequently reported being hit and verbally abused by these patients.

> So it could also be like we might have a dementia patient coming up from ED, who's been specialed [having one-to-one care] in ED, possibly restrained, possibly sedated, um, and then we know that we don't take any consideration to the best setting they should be in. We just stick them in a four bedded patient room, um, with complete, like, overstimulation.
>
> (FG1)

> I think delirium is a really big, big thing, because we're getting a lot of patients who become delirious, and then they can be aggressive. I've had a few, you're just, you're just sitting doing stuff and then all of a sudden, they'll just come at you.
>
> (FG6)

Increased visitor violence was experienced when Covid-19 visiting restrictions were enforced, either in relation to the length of visiting time or the number of visits a day. Visitors would often get different information prior to arriving on the ward and expected to be able to come into the wards with their ill family member. This lead to nurses experiencing a lot of aggression and anger from the family.

> ...it was his mum and his sister who were the most aggressive ... and they, I remember being here one day and they'd already been to visit him. They were only meant to come once or twice a day, and they'd already done that quota and they had stayed longer than they were supposed to.
>
> (FG4)

> Or another one is they allow visitors to come up with patients from ED after visiting hours ... and don't forewarn them at all that they won't be allowed to stay and the second they ... get up here, we have to tell them ... you need to leave. And then unpleasant situations arise all the time.
>
> (FG1)

Furthermore, there was sometimes a lack of consistency between the nurses that meant some nurses were more lenient about the visitor restrictions than others. This led to some families being increasingly angry with the changes and the implementation of the visitor restrictions.

> Like, we might not necessarily agree with how restricted everything is or how it's changing all the time, but we have to be the carrier of that message and then we're the face of it so then we cop it from the family members or even the patients.
>
> (FG1)

The nurses who participated in the focus groups recognized many risk factors associated with the hectic and changing context and being in the frontline as nurses often made them the target of violence.

> We're always around. Yeah ... We're the first person they see ... we're the last people they see. They blame you.
>
> (FG3)

4.10.2 | It can feel like a battlefield

This theme encompasses a range of violence experienced by the nurses. This included verbal, physical, racial and sexual abuse and violations. Verbal violence was described in all focus groups and included multiple occurrences of swearing, yelling and name-calling from patients and visitors.

> A lot of swearing eff, eff, eff this, and then, um, you know, like ... just like a lot of verbal, a lot of verbal stuff.
>
> (FG6)

> That was an incident with a patient and a very, very, very aggressive family, um, that was quite prolonged .... It involved a lot of verbal and physical violence.
>
> (FG3)

Numerous accounts of physical violence were also detailed by many nurses in all focus groups, where they had been hit, kicked and were physically attacked.

> I remember in an incident where a nurse was on a night shift, she was dragged down a stairwell by a confused patient ... and she couldn't free herself from him.
>
> (FG1)

This also included damaging hospital property and equipment where the incidents were not isolated.

> Um, and he was aggressive in the sense, he was in a single room, would come out, smashed a few of our computers, would go chasing the staff down the hallway, anything, he would rip baskets off, you know the metal baskets to put folders in? Yeah ... He'd rip that off, rip things off his walls in his room, broke the kitchenette door, slammed it shut, he broke that. So this wasn't just one incident.
>
> (FG6)

Some of the verbal abuse was so severe and continued outside the ward area.

> ...and they were ringing the ward ... follow our staff and, um, may cause harm to the staff. That was bad ... and they pulled all the monitors. ... Yeah, it was pretty awful.
>
> (FG3)

Sexual abuse was also reported by some of the nurses.

> She had a sub-cut in and when I put the morphine through she would, urgh, I was like close to her stomach and she would just like moan. And I was like, no, I'm out, like I can't.
>
> (FG2)

> It's not always the violence. Sometimes it's the comments of a sexual nature that we get all the time ... Yeah, I've had that as well.
>
> (FG3)

Racial violence had also been experienced by nurses, as they recalled patients who refused to be nursed by them because of their nationality or made overt racially abusive comments.

> So she doesn't like anyone else that's not, like Australian ... and like everyone here is Australian ... Don't be a racist [laughs] Yeah ... But last night she—she called her—what did she call her? A second, a third—from a third world.
>
> (FG2)

These nurses stated that they had used some of their interpersonal skills to avert violence that they believed to be de-escalation strategies. At times, however, they found that as a function of the multiple demands on their time, and the hectic context within which they worked, their efforts to engage with the patients was limited.

> Cause we're deescalating all these patients and doing all this stuff, and then we're still just getting abused by all these patients at the end of the day. Yeah ... and a lot of people aren't comfortable or confident.
>
> (FG3)

4.10.3 | The aftermath

This theme illuminates the impact violence had on the nurses. There were personal and professional ramifications consequent to the frequent exposure to violence in the workplace. In the immediate aftermath of a violent event most of the nurses reported being shaken and scared by the events.

> I'm not super good when I've someone in my face. I get very traumatised by that, or I'll cry [laughs] before I do anything else, but it's not crying because I'm sad ... I'm crying cause I'm mad ... I'm scared and I'm mad.
>
> (FG3)

> I'm just like, almost in this heightened state, where you're just panicking.
>
> (FG2)

> Um, in tears. They send me for a break, just to calm myself down, because I've just never had that experience before. And he's very tall, lean, strong man too.
>
> (FG5)

Other nurses reported taking leave to recover from the violence they experienced.

> Yeah, I didn't ... I didn't come to work the next night. I said, I ... I can't come back after that.
>
> (FG4)

In response to the frequent occurrence of violence, some of these participants questioned why they should continue to work in the profession expressed an intention to leave nursing.

> And so, people need to be mindful of it's your life, it's your body, this is just a job. You can go and work in a supermarket and be better off.
>
> (FG1)

> I really like, you know, to the point, like, you know, I've been nursing for a long time. The point like I question myself, do I really have to go, continue nursing. I thought, you know what, I don't want to put up with this. And I just ... and I never really like question myself ... how long can I be like, working as a nurse.
>
> (FG2)

There was a shared acknowledgment that the repetitive exposure to violence affected them outside of work and impacted on their home and family life.

> I feel like we've become ... like sponges, really. Yeah ... but I've noticed then, when I go home, I'm depleted. I have no energy, like to spend time with my family. Or I become, uh, not ... I'm not aggressive, but I do then take the frustration out on my family. Yeah. You

> become … short. Yeah … I'm snappy. Yeah. I become snappy. Just burnt out. Little things trigger me, which they shouldn't really. But they do.
>
> (FG2)

Reporting or under reporting violence was complex, situational and dependent on how the nurse perceived they would be supported. The hectic context, the frequency of violence meant that these nurses felt they did not have time to officially report all the violent incidents they experienced. However, they did recognize that by not reporting violent incidents, it officially seemed that there were minimal episodes on the ward.

> It's a barrier for putting in a report for violence and aggression, you don't have time to do that … That's the main reason why … You don't have time at all. Like you're too busy….
>
> (FG3)

> …it's detrimental to us getting any help in the long run by not reporting it because on paper there's been no violent incidences. So, we're all good from that perspective.
>
> (FG1)

Some of these nurses also became resigned to feeling violence was part of the job.

> I feel like it's becoming desensitised—well, I am to all these incidents, and I don't really, you know, report it or anything, because it's something that happens on us every single day. And, yeah, it is what it is. I guess it just comes with the job … violence … even though it shouldn't.
>
> (FG3)

Additionally, these nurses were concerned that there was often little or no consequence for the patients and visitors who were violent, and their status as a patient protected them from consequences.

> It's not my fault I was sick. It's not my fault. Yeah, exactly. Like … Well, that's right … there's always someone else to blame. Things that happen to you here, if you're hurt by a patient, you would charge someone for that on the … on the outside.
>
> (FG3)

It is clear from the findings that there are physical and emotional consequences because of the violence experienced by these nurses. Nevertheless, these nurses continued to engage with patients and their families and deliver high-quality nursing care and, as one nurse said, *we make terrible situations better just by virtue of working hard* (FG1).

4.11 | Post-implementation focus groups

Post-implementation focus groups were conducted in October 2022. Nurses' opinions and experiences of violence after the implementation of Safewards interventions, and the effect they felt Safewards had on their nursing practice was explored (see Appendix S2). Twenty-two nurses participated in the six post-implementation focus groups, 20 female and two males, most participants were in the 31–40 age group, with an average 9 years' experience as a nurse (<1–28 years) (see Table 2).

4.12 | Themes

Overall, the implementation of Safewards interventions was well received, and the nurses felt like they had improved skills in managing potentially violent situations with one participant describing it as *'a game changer'*…Much of the post-implementation focus groups' conversations focused on the Safewards interventions. Three themes remerged from the data: '*Safewards in action*', *'Empathy and self-reflection*' and '*Moving forward*'.

4.12.1 | Safewards in action

Most of the participants had received some form of violence prevention training throughout their nursing career. Several mentioned that the use of 'Soft Words' and 'Talk Down' from the modified Safewards were a reminder of what they already knew.

> I think it just reinforced things that I kind of already knew but sort of forgot about. Um, so just remembering, you know, that I have all these skills to be able to deescalate and that it's okay to be able to use them … and I think that's something that, you know, I'd like to try and keep up cause I think it's been really good for everybody.
>
> (FG5)

The nurse participants reported improved communication with patients after the implementation of Safewards. They felt they could prevent situations from escalating and felt better equipped and more confident with the Safewards 'Talk Down' tips when needed.

> I feel pretty comfortable, like if anything did happen, I think I'd be able to stay pretty calm and sort of ask questions about how they were feeling. Um, yeah, I guess it's just putting that into play and seeing what happens.
>
> (FG6)

Importantly, the participants' narratives gave details of how they were better able to recognize signs of potential violence and how they found the interventions useful in deescalating a potential aggressive situation.

> So, we can hear the agitation in their voices and things like that. So, we're trying to like calm everything down before to the point where we have to … they're really riled up and then we have to start implementing those talk round things. So, I find them useful.
>
> (FG2)

There was an abundance of conversation from the participants on how Safewards and the implemented interventions gave them a framework to guide their management of difficult situations with several participants describing how the prompts gave them alternative interventions to try.

> If you're sort of guided by the strategies, you can sort of like, oh okay, I remember this' … Um, yeah, it just gives you that little bit of, um, more concrete in your head, that these are the steps that you need to do and the strategies you can use kind of thing.
>
> (FG5)

Another participant agreed and described how the interventions gave her a 'back up' on what to say.

> Sometimes it's like someone is getting annoyed or whatever and you don't know what to say to them, it's kind of nice to have, like, rote words, what to say in those situations so you can kind of have that as your back up script.
>
> (FG2)

One participant described how she thought she would *'give it a go'* and use the interventions. She expressed surprise when they actually worked.

> A few weeks ago, I think … I got similar patients that tend to be a bit rude sometimes, and just tried to deescalate using Safewards, soft words; it helps!
>
> (FG1)

Conversation arose in the focus groups on how emotionally difficult situations can be. One participant describes how in addition to building her confidence, her application of Safewards further prepared her emotionally.

> I felt pretty like prepared when he was yelling at me. Like, I wasn't going to cry.
>
> (FG5)

All the participants reported utilizing Safewards which has become common place on these wards, with one participant describing it as '*now just part of our job*' (FG3).

4.12.2 | Empathy and self-reflection

This theme highlights how nurses developed the ability to better empathize with their patients after the implementation of Safewards. They describe being more insightful about the reasoning behind patient or visitor violence and trying to understand what was happening to better address their needs.

> …(Safewards) helps us how to escalate or deescalate … just really be wary of things while before it's just like, oh, … he's so aggressive, blah, blah, blah … but now it's kind of oh, there is a reason for this behaviour.
>
> (FG4)

There was a recognition by participants that at times, their practice was not always effective and included dismissing their concerns. They describe how after the implementation of Safewards they acknowledged that they needed to open the lines of communication with their patients and put themselves '*in their shoes*'. Stories around empathy were strong in the focus group data. As nurses, they describe themselves as caring and compassionate, and that Safewards reminded them of their ability to be empathetic. This insight was evident in many of the participants' stories as they realized that taking the time to listen and address concerns was an important alternative strategy that deescalated conflict.

> I had one the other day about, like, a patient's family getting quite upset that they can't come and visit. They got very, like, angry, a bit aggressive about it. Um, obviously I used the, like, soft words but then also, like, did like, the strategy where I put myself in their shoes and told them that, like, I understand you want to be here for your family, like, it's a tough time, but like, we're doing this to protect other patients.
>
> (FG1)

> They're probably scared … they're probably not actually angry, it's more just fear. So, to kind of put yourself in their shoes, if this was your family member, how would you be feeling?
>
> (FG6)

Safewards also gave them the tools to look at their own behaviour through a process of self-reflection and how this may potentially contribute to escalating issues. Some describe having to step away in order to diffuse the situation.

> …patients can make you so angry. And you just need to step out and calm yourself down.
>
> (FG5)

The Safewards interventions gave them the initiative and motivation to persist in diffusing the situation:

> …when you step out from a situation if it's a bit too much, I feel like, for me, that's when, like, the, like, soft words and that, sort of thing, comes back to me and I might go in and, like, try again just to chat to them and explain it a bit better.
>
> (FG5)

This process of self-reflection was clear in the focus group interviews. They specifically mentioned the 'Soft Words' and 'Talk Down' intervention when talking to patients, being mindful of what they were saying and how they were speaking. This included their realization that their words may impact on others and the implications this could have:

> I feel like it just made me kind of stop and think a little bit more when someone was getting agitated about how my words would impact the next steps.
>
> (FG2)

This also included looking at their own emotions and how their non-verbal communication may be perceived by others:

> Yeah, and like, my own emotions and, like, how I might be portraying myself, I might, like, look a bit angry.
>
> (FG5)

4.12.3 | Moving forward

Participants in the focus groups made several suggestions on how Safewards could be improved. Debriefing was mentioned predominantly and how the opportunity to do this would assist them in managing the personal repercussion of violent or aggressive incidents.

> I think probably a debrief would be a really good part of Safewards in the sense of healthcare and public service jobs, as some of the only jobs you can't bring your personal life to work, and you can't take your work life back home.
>
> (FG4)

Others saw debriefing as an opportunity to 'vent' and as a chance to support each other's knowledge and provide feedback to each other.

> …and if anything does happen, have, like, a debriefing session afterwards and, you know, not putting blame on anyone but saying like, Oh, maybe—maybe we could try this next time if a similar situation comes up.
>
> (FG6)

While the participants in the focus groups suggested debriefing to improve the implementation of Safewards, it was evident from their narratives that they were supportive of each other in ensuring the intervention worked.

> …and then we're able to remind each other … like, remember the other day we were discussing this … and yeah, keeps each other on track.
>
> (FG5)

> And we can always learn something from each other anyway, by they're different experiences too….
>
> (FG4)

While participants demonstrated their commitment and enthusiasm for the implementation of Safewards, they describe occasions where they were unsuccessful, despite using the interventions:

> …with just some people, it's not going to matter if you use soft words, or no matter what you do, there will be absolutely no appeasing.
>
> (FG5)

Despite the positive feedback from most participants in the focus groups, there were some that expressed their despair and frustration in the regularity of these situations which was reflected in their willingness to persist with the intervention:

> I've now started implementing, um, explaining what I'm doing beforehand. If the patient is still upset after I've tried to explain myself, I don't continue to try and explain myself, because it's just going to aggravate the situation. Listen to listen to them and say, I understand how you're feeling, and try and see it from their point of view. And, if it's not resolving, it's just getting escalated, step away.
>
> (FG1)

This was also evident in a statement by another participant who lacked the enthusiasm to try any intervention:

> …it gets to a point where the Safewards and stuff … you're over it.
>
> (FG4)

5 | DISCUSSION

There is an abundance of literature on patient violence against nurses, with a significant focus, on mental health workplaces and EDs. The personal and professional sequela of workplace violence is well reported. There is, however, a distinct lack of research that has examined this phenomenon in the context of general nursing in medical and surgical wards. In this study, the focus groups conducted prior to the implementation of the Safewards interventions, report similarities to the literature. Their experiences included verbal violence and included multiple occurrences of swearing, yelling and name-calling from patients and visitors and accounts of physical violence, racial and sexual abuse which align with contemporary literature (Bernardes et al., 2020). They identified precursors to the violence, including a lack of communication or miscommunication that was detailed by Najafi et al. (2018) and delays in treatment described by Basfr et al. (2019) and Tan et al. (2015) in the mental health setting and EDs respectively. They also spoke of the personal and professional ramifications to the frequent exposure to violence including taking leave, the impact it had on their home lives and questioning their choice of career with some expressing an intention to leave. This is consistent with the literature which also highlights violence as a significant contributor to the retention of nurses (Jeong & Kim, 2018).

Participants in the pre-implementation focus group indicated that at times, they tended to tolerate workplace violence. It is well documented that violence is significantly underreported in healthcare settings (Acquadro Maran & Varetto, 2018) and the participants from this study were no exception. The literature has provided numerous explanations for the underreporting of violence including feelings of guilt or shame, a lack of time and concern about consequences (Spencer et al., 2023). These factors coincide with the participants' narratives in this study and highlight a perception that there would be ineffective consequences for the perpetrator. Somani et al. (2021) explore this concept and concur that nurses may have the belief that workplace violence is a normal part of their role. However, it was evident that participants in this study experienced stress as a consequence of violence and failure to address this issue can have a negative effect on those involved.

This study introduced modified Safewards interventions on two general hospital wards using PAR. The intention of Safewards was not to provide a rule-bound, one-size-fits-all intervention. Rather, the Safewards team provided detail of the 10 Safewards interventions and the ward nurses selected two that were seen as most useful for implementation. The inclusion of the ward nurses in the research process was a powerful approach that empowered them to have a voice in addressing the issue of workplace violence and successfully implement the interventions into practice. Their involvement in the action research cycle to modify the Safewards interventions using language and terminology appropriate for their wards also increased motivation leading to a belief that they could reduce violence in their environments, creating a sense of empowerment whereby positive change could result (MacDonald et al., 2018). Additionally, the literature notes that a barrier to the successful implementation of Safewards in mental health and forensic mental health settings, is the inclusion of staff in the process (Hamilton et al., 2023) and creating a unified vision of the potential benefits of Safewards is essential (Fletcher et al., 2021).

After the implementation of the modified Safewards interventions, post-implementation focus groups interviews were completed. The participants in this study were keen to share their stories of using 'Soft Words' and 'Talk Down' and were overall positive of their Safewards experiences. Most participants in this study had received violence prevention training in the past, and their knowledge and understanding of Safewards reinforced this training and motivated them to re-engage with the interventions. They felt better equipped to prevent situations from escalating and significantly more confident using 'Soft Words' and 'Talk Down' when needed. These findings are consistent with a similar study by Ferrara et al. (2017) who explored the use of de-escalation training to medical and surgical nurses in the acute care setting.

The effectiveness of de-escalation techniques relies on interpersonal and communication skills according to the American Association for Emergency Psychiatry (AAEP) workgroup (Ferrara et al., 2017) and while the modified Safewards interventions have similarities to general de-escalation techniques, these are not universally defined or practiced and there is considerable variation (Hallett & Dickens, 2017). The purpose of this study was to take specific, well-defined interventions and modify them at ward level.

The nurse participants in the post-implementation focus group described improved communications with patients and acknowledged they needed to take the time to listen and address the concerns of their patients. This also required them to self-reflect and recognize how they may be perceived when dealing with patients that may be distressed or agitated. Safewards gave them the tools to look at their own behaviour and how this may potentially contribute to escalating issues.

Importantly, the participants describe how Safewards, and the implemented modified interventions gave them a structured and relevant framework to guide them and permission to try alternate approaches. They demonstrated an ability to work together in implementing Safewards, improving cohesion and morale within the team. This is significant as previous research has found that negative morale in staff increases the risk and likelihood of conflict (Fletcher et al., 2019). The post-implementation focus group understood the importance of debriefing and suggested this be included as an ongoing strategy as they felt it would assist them in managing the personal repercussion of violent or aggressive incidents which is important for their professional and private lives. This aligns with the literature that suggests debriefing is essential in promoting healthy coping strategies and for emotional regulation (Goodman et al., 2020).

Overall, the implementation of modified Safewards interventions on two hospital wards was successful and a valuable tool in

prevention of violence within the workplace. However, it is essential to note that there will be instances and situations where intervention will not always be successful. There will also be patients and/or visitors that will not be receptive to the interventions (Fletcher et al., 2019).

6 | STRENGTHS AND LIMITATIONS OF THE WORK

Most work on violence towards nurses use quantitative self-reporting retrospective survey designs with limited work undertaken on the experiences of violence towards general hospital nurses. A strength of this study is it collected qualitative data based on focus group methods to highlight the narratives of general nurses and their experiences of violence. Furthermore, this is the first study that reports the successful implementation of two Safewards interventions in a general hospital setting. The rigour of the study was supported by the adherence to the action research approach and intensive human resources were used to promote the success of the project. Additionally, the methodology and process are clearly identified enabling replication of this study. A limitation of this study is the Safewards interventions were introduced in two wards from one tertiary metropolitan hospital thus the transferability of the findings may be limited. Additionally, there was no corroborating quantitative data.

7 | RECOMMENDATIONS FOR FURTHER RESEARCH

Further research using the methodological approach could be undertaken in other nursing specialties such as primary healthcare or outpatient departments. Future research may benefit from including the multi-disciplinary team, such as medical or allied health staff, to reduce violence towards all members of the healthcare team within a hospital setting. Both pre- and post-focus groups suggested debriefing following violence. Further research could be undertaken to look at the efficacy of introducing post-incident debriefing in medical and surgical hospital wards. Further benefits and use of other interventions may be seen if future research included the patients and their visitors.

8 | IMPLICATIONS FOR POLICY AND PRACTICE

In the interests of safety, successful strategies to reduce violence towards general hospital nurses should be a priority for managers and healthcare organizations. Averting, mitigating and managing violence can decrease the negative professional and personal impacts on nurses and ultimately improve well-being, job satisfaction and retention rates. Furthermore, decreasing violence or aggressive incidents leads to a safer patient experience and decreased number of nursing errors. Introducing 'Soft Words' and 'Talk Down' into preregistration nursing programs and in violence prevention training for medical surgical nurses could decrease the perception that decreasing conflict is only for mental health nursing contexts.

9 | CONCLUSION

Safewards is an evidence-based model for reducing conflict and containment in mental health services and this study demonstrated the success of its use on two general hospital wards. Using PAR, the nurses as co-researchers, successfully modified the two interventions 'Soft Words' and 'Talk Down' to implement on their wards and integrated into their nursing practice and ward culture. Findings show that the implementation of the interventions provided these nurses with new skills and empowered them to avert and respond to violence appropriately. Using Safewards interventions in general hospital wards had a positive impact on minimizing patient and visitor violence.

AUTHOR CONTRIBUTIONS

Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data: LL, MW, FM. Involved in drafting the manuscript or revising it critically for important intellectual content: LL, KK, MW, GD, FM. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content: LL, KK, MW, GD, FM. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved: LL, KK, MW, GD, FM.

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CONFLICT OF INTEREST STATEMENT

The authors have no competing interests to declare.

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DATA AVAILABILITY STATEMENT

Data available on request from the authors.

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SUPPORTING INFORMATION

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