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GNRS 586

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Evidence Based Practice – BSN Competency

Evidenced based practice is crucial to the clinical field because it provides the best current evidence for optimal health care that is also centered around patient/family values and preferences. It is important to integrate evidenced based practice in the medical field so that patients are receiving the most recent optimal care that has been researched and approved by clinical expertise. It's also important as nurses to read original research and evidence reports related to areas of practice so they can be used to provide optimal care on their designated units and so they can participate in structuring the work environment to integrate the new evidence into their standards of practice.

In clinicals, I gained a lot of experience on evidenced based practices. I have seen all the nurses I have shadowed following evidenced based practices that have been formulated throughout the years of research and observations on ensuring quality patient centered care. I have grasped these skills that I have learned by practicing hands on to ensure that I am also learning how to provide patient care that is evidenced based in order to provide optimal care. For example, when you're performing a nasopharyngeal suction, it is important to hyperoxygenate the patient prior to the procedure to increase their oxygen saturation and prevent a decrease in their oxygen levels during the suctioning. I have also learned about this competency from my Scientific Writing course in my nursing program. This course has taught me about evidenced

based practices, the research, and how their implementations create a positive change in the medical field.

I will continue to show competence in this practice by ensuring I follow optimal evidenced based practices in order to provide quality patient centered care. I have also shown competence by completing assignments in my Scientific writing course that has been guiding me to create a systematic review on an evidenced based practice that has been implemented in healthcare (the most recent assignments have all been included in an outline that is attached below). Specifically, my topic is on the implementation of the Safewards model in psychiatric care to reduce coercive measures. It is an evidenced based model that is aimed at using interventions in psychiatric settings to minimize conflict and restriction by improving of safety and staff-patient relationships. The evidence has shown that this model does reduce conflict and improves safety in psychiatric settings while also creating trusting staff-patient relationships.

Scientific Writing – Evidenced Based Clinical Project

Topic: Implementation of the Safewards Model to reduce coercive measures in psychiatric care

Problems/Questions:

1. Evaluation and impact of the implementation of the Safewards Model in reducing coercive measures psychiatric care
2. Nursing perceptions and experiences on the Safewards Model in psychiatric care
3. How does reducing coercive measures in psychiatric care impact patient outcome?

PICOT

In nursing care for psychiatric inpatients (P), does the implementation of the Safewards Model (I) compared to having no model implemented (C) reduce coercive measures (O) over the initial treatment period?

The use of coercive measures is a clinical problem in psychiatric care because it can lead to violent patient episodes that may be harmful towards other patients and staff, it can create contradictory attitudes or feelings from patients and staff, and it can damage staff-patient relationships (Stensgaard, et al., 2018, p. 147). Because coercive measures are ethically and clinically questionable, it has become a clinical and political priority to reduce the use of coercion in psychiatric care (Stensgaard, et al., 2018, p. 147). The Safewards Model is an evidence based model that is aimed at using interventions in psychiatric settings to minimize conflict and restriction by improving safety and staff-patient relationships (Lee, et al., 2021, p. 1).

IV, DV, & Literature Search

To find peer-reviewed literature to support the Safewards model implementation in psychiatric care to reduce coercive measures, two databases were utilized through Azusa Pacific University's Library. The databases searched were the Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus with full text and Medline with full text. Keywords included "Safewards model,"- "psychiatric care or mental health care," and "coercive measures." Modifiers included the last ten years since publication, full text available, and written in English. This initial search found 158 peer-reviewed articles available for review. Of those 158 articles, 8 were found to be relevant to the current PICOT question: In nursing care for psychiatric inpatients (P), does the implementation of the Safewards Model (I) compared to having no model implemented (C) reduce coercive measures (O) over the initial treatment period?

IV: Safewards Model & DV: Coercive measures

Clinical Practice Guideline

The use of coercive measures is a clinical problem in psychiatric care because it can lead to violent patient episodes that may be harmful towards other patients and staff, it can create contradictory attitudes or feelings from patients and staff, and it can damage staff-patient relationships (Stensgaard, et al., 2018, p. 147). Because coercive measures are ethically and clinically questionable, it has become a clinical and political priority to reduce the use of coercion in psychiatric care (Stensgaard, et al., 2018, p. 147). The Safewards Model is an

evidence based model that is aimed at using interventions in psychiatric settings to minimize conflict and restriction by improving safety and staff-patient relationships (Lee, et al., 2021, p. 1). The development of this model occurred in the United Kingdom to examine 'conflict' events (events that threaten patient and staff safety, whether it be harm to self or others) and 'containment' (things healthcare workers do to prevent or reduce conflict events, including coercive measures). The *Safewards Handbook* (2016) from the Department of Health and Human Services of the state of Victoria, Australia was created to provide a clinical guideline on the implementation of the Safewards model in everyday practice. It provides thorough information on the overview of the Safewards model, the interventions commonly used, implementation and education of the model, trials and practices, and templates to support the implementation and training of the Safewards model. The AGREE II instrument is a tool used to appraise clinical practice guidelines. It contains 6 domains that present with questions, each of them requiring a scoring on a Likert scale of 1-7 with 1 being strongly disagree and 7 being strongly agree. These domains will be used to assess the *Safewards Handbook (2016)* and gather an overall assessment score.

Domain 1. Scope and Purpose

Domain 1 presents with three questions, totaling a score of 21. For the first question, the objectives of the guideline are specifically described in the handbook, so a score of 7 is given. The second question was also given a score of 7 because health questions are covered by the guideline and are specifically described. A score of 7 was also given in the third question since the population to whom the guideline is meant to apply to is specifically stated in the handbook.

Domain 2. Stakeholder Involvement

For the second domain, a total score 13 out of 21 was given. For the first question, 4 points were given because there was minimal explanation about systematic methods used to search for evidence. The second question also received a score of a 4 because the criteria for selecting evidence is not entirely clear. The third question received a score of a 5 because although the handbook describes the strengths, it has little information about limitations of the body of evidence.

Domain 3. Rigour of Development

Domain 3 received a total score of 31 out of 35. The first question received a score of a 7 because the handbook clearly describes the methods for formulating the interventions. The second question got a score of a 7 since the model considered the benefits, risks, and side effects in formulating the interventions. A score of a 7 was given to the third question as there is an explicit link between the recommendations and the supporting evidence. The fourth question received a score of a 7 because the guideline was externally reviewed by experts prior to its publication. Lastly, the fifth question receives a score of a 3 because there is little to no information about procedures for updating the guideline.

Domain 4. Clarity of Presentation

A total score of 21 out of 21 was given to domain 4. The recommendations are specific and unambiguous in the guideline, so the first question receives a score of a 7. The second question also receives a score of a 7 because different options for management are clearly presented. A

score of a 7 is also given to the third questions because the key recommendations are easily identifiable in the handbook.

Domain 5. Applicability

Domain 5 presents with four questions. The first question received a score of a 4 because it does not fully describe barriers to its application. The second question gets a score of a 7 because the handbook provides tools on how the implementations can be put to practice. A score of a 7 was given to the third question because resource implications have been considered in applying the interventions. The fourth question receives a score of a 3 because there is little information about monitoring or auditing criteria. Therefore, domain 5 receives a total score of 21 out of 28.

Domain 6. Editorial Independence

The last domain receives a total score of 4 out of 14. The first question gets a score of a 2 because there is no information about the funding and its influence on the content of the guideline. The second question gets a score of a 4 because group members have been recorded and addressed, but there is no information about competing interests of the guideline development.

Overall, the Safewards Handbook (2016) from the Department of Health and Human Services of the state of Victoria, Australia has various information about the overview of the model, its interventions, and education about implementation of the model. The overall quality of this guideline receives a total score of a 5 out of 7 because although there is clear information about the scope and purpose, the development of interventions and implementations, its applicability, and education on implementing the model, the guideline lacks information about barriers, limitations, auditing criteria, stakeholder involvement, and procedures for updating the guideline. Despite the information it lacks, I would use this guideline to change restrictive measure use in psychiatric settings. I would also recommend this guideline for use, but with modifications so that limitations, barriers, and procedures for updating the model can be explained thoroughly to grasp a full picture of its implementation and possible improvements if necessary.