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ORIGINAL ARTICLE

Getting a grip on Safewards: The cross impact of clinical supervision and Safewards model on clinical practice

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ABSTRACT: *The Safewards model is used across various mental health settings to reduce incidents of conflict and containment and its efficacy in reducing the use of seclusion and restraint, improving patients' experiences of care, and enhancing safety within clinical settings is well documented (Bowers,* Journal of Psychiatric & Mental Health Nursing*, 21, 2014, 499). However, there are barriers to successful implementation, including level of staff buy-in (Baumgardt et al.,* Frontiers in Psychiatry*, 10, 2019, 340; Price et al.,* Mental Health Practice*, 19, 2016, 14). This mixed-method study assessed the impact of adopting a Safewards model within a clinical supervision framework in an approach, named Group Reflective integrated Practice with Safewards (GRiP-S), which integrates Safewards theory within the clinical supervision framework. Both quantitative and qualitative data were collected using the questions derived from the Manchester Clinical Supervision Scale −26© (Winstanley & White,* The Wiley International Handbook of Clinical Supervision*. John Wiley & Sons Ltd, 2014). A total of 67 surveys and eight interviews were completed by nursing staff. Overall, the results showed that the GRiP-S approach improves the implementation of Safewards and nurses' clinical practice. Nursing staff satisfaction with clinical supervision and Safewards improved post GRiP-S pre-GRIP-S- 69.54 (*SD *16.059); post-GRIP-S 71.47 (*SD *13.978). The survey also identified nursing staff's perception of GRiP-S in the restorative and formative domains of clinical supervision improved. The restorative mean score pre-GRiP-S was 28.43 (*SD *5.988) and post-GRiP-S 29.29 (*SD *3.951). The formative mean score pre-GRiP-S was 20.10 (SD 5.617) and post-GRiP-S 20.63 (*SD *13.978). The qualitative results further explained the satisfaction levels and the changes seen in perception domains. The GRiP-S approach reported (i) improved therapeutic relationships and patient centred care, (ii) improved staff communication and teamwork, (iii) barriers to GRiP-S engagement, and (iv) assistance with the change process. The results indicate that the GRiP-S approach had a positive impact on Safewards delivery and supports ongoing change of practice.*

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INTRODUCTION

The Safewards model developed by Bowers (2014) is a framework for mental health nursing which aims to reduce the use of restrictive practices. The model identifies six *originating domains* that influence and trigger incidents or "flashpoints" of "conflict" and "containment" (Bowers 2014). These are:

1. outside hospital,
2. patient community,
3. patient characteristics,
4. regulatory framework,
5. staff team, and
6. physical environment

Safewards uses the term "conflict" to describe all incidents or events of behaviour exhibited by a patient that is a threat to their or others safety, and "containment" as all staff interventions used to limit or reduce conflict events. Often containment measures are through the use of restrictive practices, which can be counter-therapeutic (Brophy *et al*. 2016; Huckshorn 2004; Mayers *et al*. 2010; Oster *et al*. 2016; Riahi *et al*. 2020; Wynaden *et al*. 2001). Safewards 10 interventions which aim to reduce conflict and subsequent containment events are; know each other, clear mutual expectations, mutual help meeting, calm down methods, bad news mitigation, soft words, talk down, reassurance, discharge messages and positive words (Bowers 2014).

BACKGROUND

Safewards has been adopted within mental health settings globally (Asikainen *et al*. 2020; Baumgardt *et al*. 2019; Fletcher *et al*. 2019; Kipping *et al*. 2019). Several studies have examined the efficacy of Safewards as a model and framework for nursing care within mental health settings and reported that it decreases incidents of conflict and containment (Baumgardt *et al*. 2019; Bowers *et al*. 2015; Dickens *et al*. 2020; Fletcher *et al*. 2017; Hamilton *et al*. 2016). Some of these studies have also identified a correlation between implementation fidelity rates and positive outcomes in relation to reduction in conflict and containment (Bowers *et al*. 2015; Fletcher *et al*. 2017; Hamilton *et al*. 2016). Other studies have identified barriers to the implementation of Safewards within clinical areas due to staff having negative perceptions towards the model or insufficient training (Asikainen *et al*. 2020; Higgins et al. 2018; Lee *et al*. 2021; Price *et al*. 2016). The impact of training and education delivery of Safewards to promote positive outcomes and improve staff attitude towards its implementation have also been researched (Baumgardt *et al*. 2019; Fletcher *et al*. 2017; Lee *et al*. 2021; Lickiewicz *et al*. 2021; Price *et al*. 2016). Kipping *et al*. (2019) identified that involving staff from initial implementation planning stages would improve staff buy-in. However, the implementation of sustainable and long-term changes of practice where nurses incorporate Safewards interventions into their daily practice has not been researched.

When deliberating methods that may improve nursing staff understanding and implementation of new clinical interventions, clinical supervision came into consideration. Within the discipline of nursing, clinical supervision has various definitions and is delivered in a variety of styles. The Australian College of Mental Health Nurses (2019) defines clinical supervision as a regular meeting between supervisor and supervisee, which is formal, structured, and purposely constructed to provide critical reflection on work issues identified by the supervisee. Clinical supervision for nurses should primarily provide a supportive and safe space for nursing staff to engage in reflective practice, which is promoted through assistance by the clinical supervisor. The aim of clinical supervision for nurses identified by the Health Education and Training Institute (2013) is:

> Improved clinical practice and professional development. Exploring new ways of working and/or dealing with difficult situations. (p.17)

With these definitions in mind, it was identified that reflective clinical supervision sessions could provide a secondary function of aiding sustainable change of practice, as presented in Figure 1.

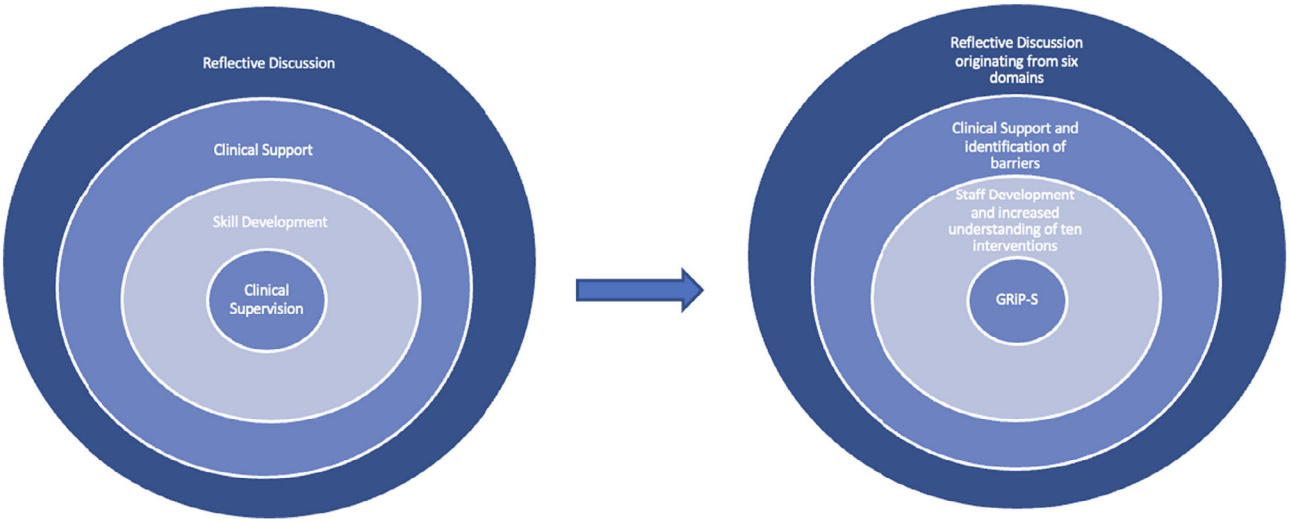

FIG. 1 Figure depicting nursing clinical supervision aims and initial development of GRiP-S approach

Group reflective integrated practice with safewards (GRIP-S) approach

The authors of this study developed a new approach to clinical supervision sessions for nursing staff, which integrated the Safewards model within group reflective practice sessions. Proctor's model for clinical supervision (1986) provided the foundational framework for the approach, identifying the need to meet formative, normative and restorative aspects of supervision. Safewards has been adapted within through acknowledging the six originating domains as pertinent to clinical supervision topics and discussions.

Prior to this study commencing the clinical setting had been considering re-configuring their clinical supervision delivery for nursing staff. The clinical setting conducted an internal audit utilizing the Manchester Clinical Supervision Scale-26© (MCSS-26©) (Winstanley & White 2014) to identify the level of satisfaction amongst nurses towards clinical supervision at that time, which consisted of informal group supervision sessions: these encouraged exchanging of ideas and dialogue between nursing staff. This provided a pre-study assessment of nursing staffs' perception towards clinical supervision prior to Safewards or the GRiP-S approach being introduced.

As part of the GRiP-S model, the six originating domains of Safewards are identified at the beginning of each session. Posters representing the six domains and 10 interventions are presented on the walls of the room where the session is held as a visual prompt. Supervisees are encouraged to identify specific examples or incidents from recent practice that they want to reflect on which originate from one of the domains.

The clinical supervisor is trained as a Safewards champion (Safewards 2013) and is responsible for supporting and encouraging professional reflection in alignment with Safewards principles. The supervisor encourages staff members to explore and reflect on clinical situations and how they may change their practice in future to better align with the 10 Safewards interventions. Staffs are also encouraged to explore and discuss how their own personal lived experiences affect their clinical management of conflict situations. The approach reinforces ongoing education on the Safewards model through consideration and discussion of practical implementation of the 10 interventions within care delivery. Further explanation on the delivery of GRiP-S sessions has been provided in Figure 2.

Prior studies have identified the use of clinical supervision in the implementation and ongoing education of nurses in the use of psychosocial interventions and counselling (Bunyan *et al*. 2017; Butler *et al*. 2014; Jørgensen *et al*. 2019). However, no prior studies identified have assessed the impact of incorporating and utilizing clinical supervision as part of a change management strategy for implementing evidence-based practice and frameworks for care such as Safewards within mental health nursing.

This study assesses the impact of incorporating Safewards domains and interventions within clinical supervision from the nurse's perspective. It is the first study to investigate the integration and adaption of Safewards

within a clinical supervision framework. It is anticipated that incorporating the Safewards model within clinical supervision will provide a positive framework for nursing staff.

Research Question: How does the GRiP-S approach affect clinical supervision and Safewards implementation within a clinical mental health setting?

Research aims

1. Assess the effect of GRiP-S approach to restorative, formative, and normative domains of clinical supervision.
2. Assess the nursing staff's perceptions and attitudes of the impact of the GRiP-S approach on their clinical practice and implementation of Safewards.
3. Assess the nursing staff's perception of the GRiP-S approach and its impact on their personal reflective practice.

METHODS

Design

A sequential mixed method explanatory study was conducted (Schoonenboom & Johnson 2017). The purpose of selecting this approach was to provide an expansion and illustration of the findings; initial findings within quantitative data, from surveys, explained and developed through qualitative data collection, from individual interviews, and analysis (Doyle *et al.* 2016). This allowed for rich and in-depth assessment of any change in nursing staffs' perception, towards clinical supervision, their clinical practice and Safewards implementation, post introduction of the adapted model and subsequent changes. In other words, assessing what impact the GRiP-S approach has had on these areas. The tool used for correlative quantitative data collection was the MCSS-26©. Findings from pre- and post-change mean cohort score analysis provided the basis for the sequential development of qualitative semi-structured interviews.

Setting

The study was carried out in a mental health unit consisting of three wards in Perth, Western Australia. There are 84 nursing staff employed within the unit. Each ward is managed by a clinical nurse manager and ward staff consist of clinical nurses, registered nurses, and enrolled nurses. Safewards has recently been adopted within the unit as a model for nursing interventions, and its domains and interventions utilized within the framework for ongoing clinical supervision sessions.

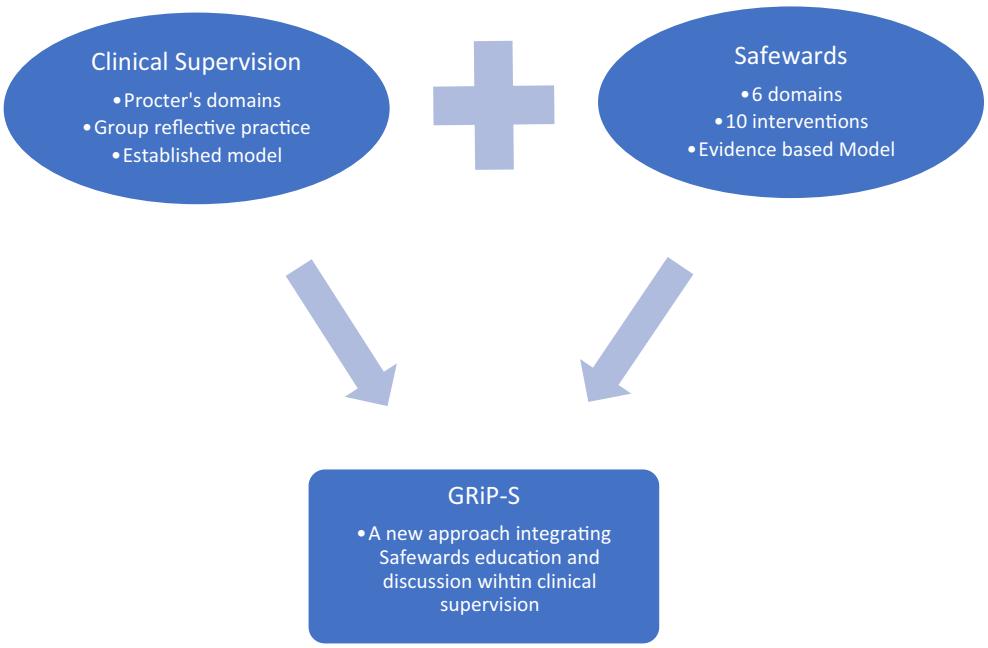

FIG. 2 Visual representation of the GRiP-S approach

Participants

Participants were recruited from nursing staff employed within the mental health unit in Western Australia. Purposeful sampling was used to ensure that all participants met the selection criteria of the study to provide a true representation of after intervention data. Inclusion criteria consisted of current employment as a nurse at the time of data collection and having previously completed the MCSS-26© as part of the unit's internal audit in 2020, in order to ensure that a true pre- and post-GRiP-S analysis was performed.

Recruitment

Nine months after the introduction of the GRiP-S approach, hard copies of the participant information letter, consent form and the MCSS-26© were distributed to all nursing staff by the three clinical nurse managers. Participants were asked to self-identify that they had participated in the earlier internal audit before completing the paper-based survey for the second time. Participant packs also included consent forms for those who wished to volunteer to also take part in the interview stage of data collection.

Ethics

Ethical approval was obtained from Ramsay Health Care and Edith Cowan University Human Research Ethics Committees. All participants volunteered to partake in the study and provided informed consent. All participants remained anonymous. At the time of this study one of the research team members worked as a line manager within the mental health unit. To prevent coercion and reduce bias, participant information packs were distributed by clinical nurse manager's and the research team were not involved in recruitment.

Data collection tools

The MCSS-26© was used to collect participant responses. The tool consists of 26 items and six subscales. A five-point Likert scale is utilized for each item. It has been synthesized to collaborate with Proctor's domains of supervision, which are: formative, normative and restorative (Proctor 1986). The formative domain focuses on development of personal skills and knowledge, the normative domain on managerial skill development and maintaining professional standards, and the restorative domain on supportive and reflective practice (Sloan & Watson 2002). The sum of each subscale indicates the effectiveness of each domain from the perspective of the supervisee. Similarly, the sum of all six subscales provides a total sum, this total ranges between zero-104; a total score equal to or over 73 indicates effective clinical supervision (Snowdon *et al*. 2020; Winstanley & White 2017). The MCCS-26© is a validated tool that has been implemented across various settings within health care (Snowdon *et al*. 2020).

Data collection

Consent was obtained to retrospectively access the data from the MCSS-26© that was completed as part of the internal audit in 2020. At this time, nursing staff were asked to anonymously complete a paper-copy of the survey, which were distributed within the workplace. The second round of surveys completed as part of this study were distributed nine months after the introduction of the GRiP-S approach. After the initial quantitative data had been analysed qualitative data was collected through individual semi-structured interviews one month later. The interviews were conducted within the hospital grounds, outside of the mental health unit, to enhance accessibility and reduce potential discomfort of participants. All interviews were audio recorded. The questions focused on explaining and illustrating the results from quantitative data analysis. An interview protocol was established by the research team prior to conducting the interviews.

Development of interview schedule

Following initial quantitative data analysis, the interview schedule was developed for semi-structured interviews. The interview questions aimed to further explain nursing staff's perception and attitude towards the GRiP-S model and its impact on their clinical practice, implementation of Safewards, and reflective practice. As well as the use of clinical supervision as part of a change management system. Participants were asked about their understanding of and implementation of Safewards, their perception of the GRiP-S model and whether clinical supervision had assisted in their understanding or application of Safewards. The interviews also aimed to further explain the quantitative data. Specifically, within the normative sub-scale. This was achieved through re-wording two questions that had negative scoring in the survey: "Is it difficult to find time for clinical supervision sessions?" and "Does

time spent on clinical supervision takes you away from your real work in the clinical area?"

Data analysis

Over 50% of nursing staff employed at the time of the internal audit completed the survey in 2020 (n = 44). This provided an adequate profile of the nursing staff's perception on the effectiveness of clinical supervision within the clinical setting prior to the introduction of Safewards or the GRiP-S approach and provided pre implementation data. A total of n = 23 nurses completed the second round of surveys in September 2021. This provided a response rate of 52.27%. This was over 50% of the original cohort. Participants were also provided with the same instructions to create a respondent code for the survey to assist with pre-post survey analysis.

All missing values were omitted and not included in final scores within subscales and domains. Due to missing values a paired analysis of pre- and post-surveys were not possible, as most participants did not provide a respondent code. Due to the small sample size, quantitative data has been descriptively presented with a focus on cohort mean scores.

For qualitative data, interviews were audio-recorded and transcribed verbatim. Interpretive phenomenological analysis with a double hermeneutic approach as outlined by Smith *et al*. (2008) was conducted. This involved a detailed analysis of the interview data by the lead researcher, initially through emersion by reading and re-reading the interview transcripts and listening to the audio transcripts. Initial exploratory notes were made from identified points of interest. The emerging themes were identified across the interviews and commonalities were categorized.

RESULTS

Participants' demographics

A total of 67 surveys were received across the initial pre and post change phase of the research project (n = 44 pre and n = 23 post). Participants were predominantly female (77.3%, n = 34 pre and 73.9%, n = 17 post), which is reflective of nursing workforce demographics nationally (Department of Health 2017). Most participants across both were aged 40 years or younger. The survey did not capture how long participants had been working within the nursing profession but did ask how long they had been working in their current position. At the time of the initial survey the largest response came from nurses who had been in their current post for less than 1 year (36.4%, n = 16). Also, the range of months receiving clinical supervision were between two and 264 in the pre-survey, and 12 and 102 in the post survey. There was considerable missing data for participants' job title; however, the highest identified respondents were registered nurses (61.4%, n = 27 pre and 56.5%, n = 13 post). On average, participants had been receiving clinical supervision for a mean average of 38 months and the highest frequency of identified clinical supervision attendance was weekly (56.8%, n = 25 pre and 43.5%, n = 10 post). Table 1 displays demographic details collected.

Nurses' perceptions – Pre- and post-implementation of GRiP-S

The following section shows cohort mean total and subscale scores of the MCSS-26© data both pre and post

TABLE 1 *Demographic details of survey participants across data sets*

Demographic details	Total participants (n = 67)	"pre" survey (n = 44)	"post" survey (n = 23)
Sex – n (%)			
Male	10 (14.9%)	6 (13.6%)	4 (17.4%)
Female	51 (76.1%)	34 (77.3%)	17 (73.9%)
Age			
Mean (SD)	35.98 (11.919)	36.6 (10.850)	37.10 (11.721)
21–30 years	23 (34.3%)	16 (36.4%)	7 (30.4%)
31–40 years	14 (20.9%)	10 (22.7%)	5 (21.7%)
41–50 years	6 (9%)	4 (9.1%)	2 (8.7%)
51–60 years	10 (14.9%)	4 (9.1%)	6 (26.1%)
61–70 years	1 (1.5%)	1 (2.3%)	0 (0%)
Current position – n (%)			
Enrolled nurse	7 (10.4%)	5 (11.4%)	2 (8.7%)
Registered nurse	40 (59.7%)	27 (61.4%)	13 (56.5%)
Clinical nurse	8 (11.9%)	3 (6.8%)	5 (21.7%)
Time in current post – n (%)			
<1 year	19 (28.4%)	16 (36.4%)	3 (13%)
1–2 years	8 (11.9%)	1 (2.3%)	7 (30.4%)
3–5 years	17 (25.4%)	9 (20.5%)	8 (34.8%)
>5 years	19 (28.4%)	15 (34.1%)	4 (17.4%)
Frequency of attending clinical supervision – n (%)			
Every week	35 (52.2%)	25(56.8%)	10 (43.5%)
Every 2 weeks	10 (14.9%)	7 (15.9%)	3 (13%)
Monthly	9 (13.4%)	4 (9.1%)	5 (21.7%)
2–3 monthly	3 (4.5%)	0 (0%)	3 (13%)
More than 3 months apart	5 (7.5%)	3 (6.8%)	2 (8.7%)
Length of time receiving clinical supervision in months			
Mean (SD)	38.83 (51.047)	39.53 (61.393)	37.65 (26.835)
Range	2–264	2–264	12–102

implementation of the GRiP-S approach, see Table 2. More in-depth descriptive analysis of individual questions focused on the data collected in the post surveys to best understand the impact the GRiP-S model currently has on clinical supervision within the study setting.

Nurses' overall satisfaction

There was an improvement in the overall level of satisfaction with clinical supervision reported by nurses over the course of the study. With the total mean adequacy scores in the pre-survey being 69.54 (*SD* = 16.059; *n* = 35) and the post-survey 71.47 (*SD* = 13.978, *n* = 19). The survey included an additional rated question on describing the level of overall satisfaction with clinical supervision being received. Pre-survey responses ranged from very unsatisfied to very satisfied, whereby post-survey responses ranged from dissatisfied to very satisfied only. Indicating that there was an improvement to nursing staff's perception of clinical supervision since the introduction of the GRiP-S model.

The post-survey domain subscale scores provided further descriptive data on specific aspects of clinical supervision. The data identified an improvement in nursing staff's perception of clinical supervision meeting formative and restorative domains. This includes clinical supervision assisting in development of the nurse's skills and knowledge, and support and encouragement through reflective practice respectively. The normative domain which includes aspects on finding time to attend clinical supervision; highlighting external barriers, and the value and importance of clinical supervision both within the workplace culture and for individual nurses had the lowest mean score across the three domains. The responses provided highlight that respondents internally value clinical supervision but there may be workplace pressures and organizational barriers to finding time to attend the facilitated sessions.

Qualitative results

Eight nursing staff participated in individual semi-structured interviews conducted by the lead researcher. Interview questions focused on extracting further explanations for the quantitative findings. Additional questions were also asked about participants' understanding and implementation of the Safewards model within their clinical area; practice of personal reflection; engagement and perception of work facilitated clinical supervision sessions; and their perception of the GRiP-S approach.

Most participants were aged between 29 and 32 years old and were predominantly female (*n* = 7), and clinical nurses' (*n* = 5). There was a large variation between how frequently interview participants attended the GRiP-S sessions, ranging from fortnightly to every three months (two weekly *n* = 3, monthly *n* = 2, two to three monthly *n* = 1, over three-monthly *n* = 2). The interviews lasted a mean of 38 min and 35 s.

Themes

Four major themes were identified as detailed in Table 3.

Theme one: Improved therapeutic relationships and patient centred care

Participants reported that the Safewards interventions had helped staff identify positive ways to engage with patients and facilitate rapport building interactions.

TABLE 2 *MCSS-26© scores obtained in "pre" and "post" GRiP-S surveys*

	October 2020 "pre" survey (*n* = 44)	September 2021 "post" survey (*n* = 23)
Subscales		
Importance/value of clinical supervision – IMV	Mean 14.18 (*SD* 3.630)	Mean 14.57 (*SD* 3.325)
Finding time – FT	Mean 7.02 (*SD* 3.790)	Mean 6.05 (*SD* 3.579)
Trust/rapport – TR	Mean 14.05 (*SD* 3.436)	Mean 14.38 (*SD* 2.376)
Supervisor advice/support SAS	Mean 14.40 (*SD* 3.223)	Mean 15.09 (*SD* 2.776)
Improve care/skills – IMP	Mean 11.28 (*SD* 3.397)	Mean 11.10 (*SD* 3.401)
Reflection – REF	Mean 8.84 (*SD* 2.828)	Mean 9.41 (*SD* 1.736)
Domains		
Normative (IMV + FT)	Mean 21.08 (*SD* 5.984)	Mean 20.76 (*SD* 6.332)
Restorative (TR + SAS)	Mean 28.43 (*SD* 5.988)	Mean 29.29 (*SD* 3.951)
Formative (IMP + REF)	Mean 20.10 (*SD* 5.617)	Mean 20.63 (*SD* = 4.810)
Total MCSS-26©	Mean 69.54 (*SD* 16.059)	Mean 71.47 (*SD* 13.978)

TABLE 3 *Extraction of themes*

Direct quotations from transcripts	Theme
"(nurses) find it really beneficial to use the interventions to engage with patients, to get a better, you know, improved therapeutic relationship" (Interview 1)	Improved therapeutic relationships and patient centred care
"it's changed our (nurses) interactions by kind of helping us to get to know the patient" (Interview 1)	
"..(getting to know you intervention) provides that time for you to establish a therapeutic relationship and getting to know the patient .. so it's changed our interactions by kind of helping us to get to know the patient, there likes and dislikes, and trying to understand what they enjoy and how we can best help them." (Interview 1)	
"it can help you structure your conversation with (patients), to get the most out of it, so that you keep that rapport. . .it's just slowly got better with time, just by kind of feeling, building, that confidence that it works by a sense of seeing 'oh that actually went better than I thought' makes me feel less anxious about dealing with those scenarios (in the future)" (Interview 2)	
"the most I've learned from Safewards is that learning to say 'no' but in a constructive way, or kind of being able to give support to someone, make them (patient) feel supported and not criticised . . . then actually you get ..a mutual good relationship because of that" (Interview 2)	
"I really enjoy the ('getting to know you' intervention). . .that has been helpful in building rapport with patients" (Interview 4)	
"I think that it has definitely helped because often..you just get (the patients) mental health history, you often forget to ask about who they are, you know, who they actually are, rather" (Interview 4)	
"..you know, you figure out what they (the patient) like and it's not just about 'you're anxious, let's give you a medication', it's like, let's figure out what you would do at home in this situation, you really enjoy reading or you really enjoy gardening, or whatever it is and try and implement that then to encourage their recovery." (Interview 4)	
". . .more about the language we use and being more, positive and a bit more open with our patients. . .more open with the relationship between patients and staff. . .I think we've put in better boundaries with patients. . .the getting to know you format, I actually think that has been helpful in building rapport with patients," (Interview 5)	
"..it's quite a nice building tool" (Interview 5)	
"I think we've (the nurses) become more approachable. . .it's easier to establish a one-on-one." (Interview 5)	
"It's been helpful in establishing care plans. . .patients seem more willing and more receptive of doing care plans with the nurses, whereas before I think it felt like it was a bit of a ticking the box kind of a thing and they weren't as involved. . .they didn't really appear to be as involved in their own care, it was more of a this is our nurse plan, this is what the nurses follow, but I feel like they're more involved in their own care now which is quite good" (Interview 5)	
"we've got that sign up on the wall saying, 'never say no', just don't say 'no' you say something else. . .offer them a solution. . .they (the patients) trust you a bit more because they see that you're actually trying to get something that they want, instead of just saying 'no sorry' and that's it." (Interview 6)	
"I think what's been more useful is that patients have seen my interests, when those photos were up (get to know you wall) so it sparked conversation. . .it was like a way of already building a rapport with her (patient) and she almost already felt safe with me, even though she hadn't even met me." (Interview 7)	
".. (Safewards helps) build the best relationship with our patients because it is true relationship that we see progress in recovery for our patients. . .made me more focused on the person rather than the medical disorder and it gave me so much, the keyword is, like humanness in dealing with the patients" (Interview 8)	
"I have learned to first have that rapport building and then to spend time with the patient to make sure that their needs are met" (Interview 8)	
"We (nurses) realised especially with Safewards that it's not just a matter of time (spent with patients) but the strategies of building rapport with patients which matter more. . .I spend more time talking to my patients" (Interview 8)	
"I think it promotes teamwork and engaging in reflective practice with each other really helps strengthen the team, you get a positive, safe environment to reflect on your practice and discuss	Improved staff communication and teamwork

(*Continued*)

TABLE 3 (Continued)

Direct quotations from transcripts	Theme
with each other how best you may be able to help the patients and recognise areas where you may have been able to improve and how best you can improve. . .” (Interview 1)	
“. . .it (GRiP-S sessions) just gets people to get to know each other.” (Interview 2)	
“. . .using positive words in handovers to kind of you know have that positive vibe coming out of handover rather than having people feeling negative about coming onto their shift or leaving their shift. . .” (Interview 2)	
“within the clinical nurse role, it’s really been specifically around the positive words and the wards resilience and kind of keeping an eye on staff and building that team resilience to try and you know look at ways you’re going to mitigate certain incidents or scenarios” (Interview 2)	
“. . . (nursing staff) are noticing more at handover if somebody is inappropriate and that it’s not, you know, acceptable language. . . I think it’s been a positive, I mean, when we’re doing handover there’s nothing worse than getting a handover that sets you off for a bad day, thinking that, you know, it’s gonna be the worst day ever and most of the time it’s not.” (Interview 3)	
“I think our staff are quite good on the ward as well, we sort of talk together quite a lot, we have huddles, all these kind of things that give us time to debrief, and then our reflective practice that’s on every week, we use that as well.” (Interview 4)	
“I’m definitely trying to invert more positive language, especially around handover, because that can often be that time of the day where you feel like you need to vent (laughs) as well, I’ve been trying to curve that. . .kind of temptation to vent at handover and just keep it as, you know, positive language. . .” (Interview 5)	
“I think (Safewards) gives the ward a little bit of a less clinical feel and a bit. More of a, I’d say a safe space” (Interview 5)	
“I feel like there has been a lot of self-awareness and being able to self-check. Also, I know, I think sometimes the senior nurses will, if (conversation between staff) is getting, escalating, they can kinda pull it back and re-align.” (Interview 5)	
“. . .especially in supervision I think we’re actually quite good at using that positive language. . . we can generally check ourselves and pull it back to where it needs to be” (Interview 5)	
“I think it’s probably made me.more, a bit more aware of how I react to things, as in like being a coordinator, you know, being less reactive . . . I guess I’m more aware now of. . .the effects that can have on the junior staff etc. or just the team. . . I’m more positive about it (workplace frustrations) and just more aware of how I react to that, it will have more of a positive effect on others” (Interview 7)	
“I love this so much (GRiP-S sessions), I really love it because the experience, the feeling it’s mutual amongst the nurses, like you’re not alone, like it’s ok to feel this way because we have felt it as well, don’t be hard on yourself, especially when you are not achieving a desired result, it’s because, it’s not just you, it’s because maybe the other party is not really engaging, so those kinds of communication and reassurance.” (Interview 8)	
“I think it’s an important part of the job, because if you don’t’ reflect you can’t improve patient care or your own clinical practice.” (Interview 1)	Barriers to GRiP-S engagement
“. . .it is hard to get off the ward sometimes, just because of lack of staff and lack of time to cover the ward.” (Interview 1)	
“It just depends on the acuity of the ward, like sometimes you feel in that moment it would be beneficial (to attend) . . .and then you end up panicky about trying to get there on time and then you’re late and then that kind of offsets how you’re feeling in that setting. . .” (Interview 1).	
“I try and focus on motivating others to go. . . like newer staff who might benefit from it more, who looks like there’s actually a lot on their shoulders that it would be good for them to go, and so I try and encourage them to go.” (Interview 2).	
“It’s at that crossover when you finish at three and there’s maybe like that business if you’re not fully ‘clocked off’ if that makes sense, because your handover if it’s a busy shift goes over.. and then you’re late (for supervision) and that kind of offsets how you feel in that setting.. it’s about time management as well sometimes.” (Interview 2)	
“. . .due to just needing enough staff on the ward. . . I think that really impacts the ability for us to send more people or to attend ourselves.” (Interview 2).	
“Because I’m a CN (clinical nurse) I’m always co-ordinating so it makes it hard to get off the ward. . .you’ve gotta take handover, you’ve gotta have handover for the incoming staff that are	

(*Continued*)

TABLE 3 (Continued)

Direct quotations from transcripts	Theme
coming in at later times. . .timing is probably the big one (barrier) because it's right during handover and shift changes" (Interview 3).	
"No, I think it's an integral part of our work because we work in mental health, you know if we're not looking after ourselves, then you know how can we look after other people" (Interview 3).	
". . .you're trying to sort of finish off tasks rather than think about starting a new task" (Interview 4)	
". . . that's often a busy time where (patients) come out from groups they, can be distressed, they want medications, its hand overtime, so yeah it can be a difficult time (on the ward). (Interview 4)	
". . .you're trying to sort of finish off tasks rather than think about starting a new task" (Interview 4)	
"I haven't managed to get to that as much as I'd like to, but I think that's more generally because I'm a senior nurse, so I think we try and get the more, the newbies in a bit more." (Interview 5).	
". . .ward acuity would be the biggest (barrier)" (Interview 5)	
"I haven't managed to get to that as much as I'd like to, but I think that's more generally because I'm a senior nurse, so I think we try and get the more, the newbies in a bit more." (Interview 5).	
". . .usually the coordinator ends up staying on the floor" (Interview 7)	
I think It's a really difficult time slot. . .you're looking at staff leaving early, you're also looking at acuity of the ward and what the staffing ratio is as well, so it depends. . .if I've got a pretty much a full workload then it's harder to facilitate that (share patient load so nurses can get to CS)." (interview 7).	
"I think It's a really difficult time slot. . .you're looking at staff leaving early, you're also looking at acuity of the ward and what the staffing ratio is as well, so it depends. . .if I've got a pretty much a full workload then it's harder to facilitate that (share patient load so nurses can get to CS)." (interview 7).	
"Attending the reflective practice as a group helps us. . .identify any barriers to. . .changes to practice to implement Safewards.. I think the reflective practice sort of helps generate an understanding and enthusiasm when you're working as a group, you can identify the pros and the cons and work through it together to encourage each other. . .you know people had training at different times. . .(it) has sort of been a process. So, I think with that in mind it's been a good space for people to come together, who aren't always on shift together, or haven't been to the training sessions together, to talk about it . . .discuss how it's helping." (Interview 1)	Assists with the change process
"I think because, you know, people had training at different times, the implementation of it has been a bit.. of a process.. so I think with that in mind it's been a good space for people to come together who aren't always on shift together or haven't been to the training sessions together to talk about it and recognise and discuss how it's helping.. and we hear peoples questions that they have" (Interview 1).	
"We've discussed and had really good feedback about how nurses notice patients reading the discharge messages on the walls in their own time, which you know gives them a sense of hopefulness from someone who's been there in their own shoes, so these are the type of things that we've discussed the positives of in reflective practice." (Interview 1)	
". . .some of the barriers were the talkdown tips and softwords, I think some (nurses) just found ..the choice of words (difficult).. like I say, we discuss it in reflective practice and it's easier to overcome with support from others" (Interview 1)	
". . .people then reflect what they were actually doing that related to Safewards . . . so it makes people be able to come out feeling more positive about the work we're doing I think." (Interview 2).	
"(Safewards) comes into scenarios. . .someone will come up with a scenario that's been a bit difficult. . .people then reflect what they were actually doing that related to Safewards . . . so it makes people be able to come out feeling more positive about the work we are doing, I think." (Interview 2).	
"I kind of reflect myself, I always go home and think about things and think, you know, could I have done something different, would it have a different outcome." (Interview 3)	
". . . if there's a patient that escalated, we will kind of talk it through, what we did and what might be, different interventions for what might be done" (Interview 4)	

(*Continued*)

TABLE 3 (Continued)

Direct quotations from transcripts	Theme
"Safewards is definitely spoken about… (we) discuss patients and interventions, different interventions for what might be done possibly." (Interview 5).	
"… (we) discuss patients and interventions, different interventions for what might be done possibly." (Interview 5).	
"… if someone's got an issue with the patient, say why do not you try this or that, or that kind of stuff, and sure, we use the strategies of Safewards" (Interview 6).	
"…the concept of Safewards is there" (Interview 8).	

Specific Safewards interventions that were identified as having assisted in communication between nurses and patients were "know each other", "clear mutual expectations", "positive words" and "talk down skills".

> …(know each other intervention) provides that time for you to establish a therapeutic relationship and getting to know the patient .. so, it's changed our interactions by kind of helping us to get to know the patient, there likes and dislikes, and trying to understand what they enjoy and how we can best help them. (Interview 1)

> I really enjoy the ('know eachother intervention) …that has been helpful in building rapport with patients (Interview 4)

> We (nurses) realised especially with Safewards that it's not just a matter of time (spent with patients) but the strategies of building rapport with patients which matter more…I spend more time talking to my patients (Interview 8)

A shared experience amongst participants is how Safewards has provided the structure and framework which improves communication with patients. This was achieved through building their repertoire and vocabulary in a way which has encouraged positive interactions and assisted when verbally de-escalating difficult situations. Participants described how they had developed skills and felt empowered to confidently engage with patients in a meaningful way. Terms such as "tool kit" and "resource" were used by participants to describe how Safewards had assisted in communication.

> it can help you structure your conversation with (patients), to get the most out of it, so that you keep that rapport…it's just slowly got better with time, just by kind of feeling, building, that confidence that it works by a sense of seeing 'oh that actually went better than I thought' makes me feel less anxious about dealing with those scenarios (in the future) (Interview 2)

> …it's quite a nice building tool (Interview 5)

> the most I've learned from Safewards is that learning to say 'no' but in a constructive way, or kind of being able to give support to someone, make them (patient) feel supported and not criticised … then actually you get …a mutual good relationship because of that (Interview 2)

Participants expressed their perception of improved respect for patient individuality and autonomy. Stating they see the patient as an individual, no longer focusing solely on their mental health diagnosis. Nurses reported now seeing the patients as "individuals" and treating them with "more humanness"; "like family". Emphasizing the improved patient centred perspective.

> I think that it has definitely helped because often…you just get (the patients) mental health history, you often forget to ask about who they are, you know, who they actually are, rather (Interview 4)

> .. (Safewards helps) build the best relationship with our patients because it is true relationship that we see progress in recovery for our patients…made me more focused on the person rather than the medical disorder and it gave me so much, the keyword is, like humanness in dealing with the patients (Interview 8)

Subsequently this led to improved patient-centred care delivery, encouraging patients to participate in care, treatment, and discharge planning.

> it's been helpful in establishing care plans…patients seem more willing and more receptive of doing care plans with the nurses, whereas before I think it felt like it was a bit of a ticking the box kind of a thing and they weren't as involved.. they didn't really appear to be as involved in their own care, it was more of a this is our nurse plan, this is what the nurses follow, but I feel like they're more involved in their own care now which is quite good. (Interview 5)

> I think we've (the nurses) become more approachable. I think it's easier to establish a one on one, do one on one therapy with (patients)… (Interview 5)

Participants described spending time with patients exploring their likes and interests to identify what positive coping strategies they use in the community which can also be implemented within the ward area. For example, utilizing hobbies and interests as distraction and relaxation techniques as a first line of distress management, before *pro re nata* (as required) medications.

> . . .you know, you figure out what they (the patient) like and it's not just about 'you're anxious, let's give you a medication', it's like, let's figure out what you would do at home in this situation, you really enjoy reading or you really enjoy gardening, or whatever it is and try and implement that then to encourage their recovery. (Interview 4)

> I have learned to first have that rapport building and then to spend time with the patient to make sure that their needs are met" (Interview 8)

Theme two: Improved staff communication and teamwork

Participants described their perception of improved communication amongst nursing staff. Participants had the shared experience of being more mindful of how their choice of words and attitude within the work environment impacts those around them. Participants consistently described how the ward environment had improved because of this and also the clinical handover.

> . . .using positive words in handovers to kind of you know have that positive vibe coming out of handover rather than having people feeling negative about coming onto their shift or leaving their shift. . . (Interview 2)

> I'm definitely trying to invert more positive language, especially around handover, because that can often be that time of the day where you feel like you need to vent (laughs) as well, I've been trying to curve that. . .kind of temptation to vent at handover and just keep it as, you know, positive language. . ." (Interview 6)

> "I think (Safewards) gives the ward a little bit of a less clinical feel and a bit. More of a, I'd say a safe space" (Interview 5)

There was a shared understanding that individual and team efforts were needed to consistently and consciously monitor the language used to promote positive discussion and common courtesy within the workplace.

> I feel like there has been a lot of self-awareness and being able to self-check. Also, I know, I think sometimes the senior nurses will, if (conversation between staff) is getting, escalating, they can kinda pull it back and re-align. (Interview 5)

> within the clinical nurse role, it's really been specifically around the positive words and the wards resilience and kind of keeping an eye on staff and building that team resilience to try and you know look at ways you're going to mitigate certain incidents or scenarios (Interview 2)

> I think it's probably made me more, a bit more aware of how I react to things as in like being a coordinator you know being less reactive. (Interview 7)

The shared responsibility of staff to promote the use of positive words has been encouraged through GRiP-S reflective practice sessions and team huddles during each shift.

> . . . (nursing staff) are noticing more at handover if somebody is inappropriate and that it's not, you know, acceptable language. . . I think it's been a positive, I mean, when we're doing handover there's nothing worse than getting a handover that sets you off for a bad day, thinking that, you know, it's gonna be the worst day ever and most of the time it's not. (Interview 3)

> . . .especially in supervision I think we're actually quite good at using that positive language. . . we can generally check ourselves and pull it back to where it needs to be (Interview 5)

The GRiP-S sessions were identified as being a space that enhances relationships between nurses. Participants reported that GRiP-S sessions are a useful space for providing support and team discussion. Huddles and unorganized ward discussions were also identified as being a positive space where nurses de-brief and seek guidance and support from teammates. The enhanced communication and mindfulness amongst staff members which has been initiated from Safewards has improved ward level support and encouragement.

> I think it promotes teamwork and engaging in reflective practice with each other really helps strengthen the team, you get a positive, safe environment to reflect on your practice and discuss with each other how best you may be able to help the patients and recognise areas where you may have been able to improve and how best you can improve. . . (Interview 1)

> I love this so much (GRiP-S sessions), I really love it because the experience, the feeling it's mutual amongst the nurses, like you're not alone, like it's ok to feel this way because we have felt it as well, don't be hard on yourself, especially when you are not achieving a desired result, it's because, it's not just you, it's because maybe the other party is not really

> engaging, so those kinds of communication and reassurance. (Interview 8)

Theme three: Barriers to GRiP-S engagement

Participants' responses in the interviews further describe the internal value nurses place on clinical supervision and their ability to find time to attend or participate.

> I think it's an important part of the job, because if you don't' reflect you can't improve patient care or your own clinical practice. (Interview 1)

Clinical nurses and registered nurses identified similar barriers to attending GRiP-S sessions within the workplace. These included the level of ward acuity and the nursing staff ratio at the time.

> . . .it is hard to get off the ward sometimes, just because of lack of staff and lack of time to cover the ward. (Interview 1)

> . . .ward acuity would be the biggest (barrier) (Interview 5)

All eight participants reported that these barriers were heightened due to the time at which GRiP-S sessions are offered (2:30–3:30 pm on Thursdays). Participants consistently reported that this was a "busy" time of the day for various reasons. Firstly, it coincides with when patients come out of afternoon group therapy sessions and are often seeking increased support from nursing staff. Secondly, it is when some patients are routinely prescribed afternoon medications which nursing staff are required to administer. Thirdly, it is during shift hand over time which has implications for the shift co-ordinator not being able to leave the ward to attend, as well as reducing the number of staff who are available to carry a patient load and take time off the ward.

> It's at that crossover when you finish at three and there's maybe like that business if you're not fully 'clocked off' if that makes sense, because your handover if it's a busy shift goes over. . .and then you're late (for supervision) and that kind of offsets how you feel in that setting. . .it's about time management as well sometimes. (Interview 2)

> . . . that's often a busy time where (patients) come out from groups they, can be distressed, they want medications, its hand overtime, so yeah it can be a difficult time (on the ward). (Interview 4)

Two participants reported that having the supervision session at the end of their morning shift was a deterrent to attending. Participants expressed at this time of the day they are mentally tired and not prepared to engage in supervision sessions preferring to leave work and get home earlier.

> . . .you're trying to sort of finish off tasks rather than think about starting a new task (Interview 4)

Of the eight staff interviewed clinical nurses consistently reported that their status as a senior nurse or shift co-ordinator hindered their frequent attendance of GRiP-S sessions. Three out of five clinical nurses reported they would like to attend more frequently. This is partly due to their attempts to encourage more junior staff to attend instead, believing they will find it more beneficial, and out of an internal sense of encouraging and supporting less experienced nursing staff.

> I haven't managed to get to that as much as I'd like to, but I think that's more generally because I'm a senior nurse, so I think we try and get the more, the newbies in a bit more. (Interview 5)

> I try and focus on motivating others to go. . . like newer staff who might benefit from it more, who looks like there's actually a lot on their shoulders that it would be good for them to go, and so I try and encourage them to go. (Interview 2)

Alongside this, clinical nurses reported the following additional barriers; increased work demands, facilitating clinical handover, and responsibilities relating to coordinating the ward. There was a shared perception amongst clinical nurses that they do not have the ability to attend GRiP-S sessions as frequently as other staff due to work duties and responsibilities.

> . . .usually, the coordinator ends up staying on the floor (Interview 7)

When asked if clinical supervision takes them away from their "real" work participants consistently disagreed. All participants expressed that they placed value in clinical supervision, and many stated that attending sessions was important and valuable to their professional role. The belief in and value of clinical supervision for the individual participants was evident.

> No, I think it is an important part of the job, because if you don't reflect you can't improve patient care or your own clinical practice (Interview 1)

> No, I think it's an integral part of our work because we work in mental health, you know if we're not looking after ourselves, then you know how can we look after other people? (Interview 3)

Theme four: Assists with the change process

Participants who have been attending GRiP-S sessions had different perceptions on how Safewards was integrated within the sessions.

> We've discussed and had really good feedback about how nurses notice patients reading the discharge messages on the walls in their own time, which you know gives them a sense of hopefulness from someone who's been there in their own shoes, so these are the type of things that we've discussed the positives of in reflective practice. (Interview 1)

> people then reflect what they were actually doing that related to Safewards (Interview 2)

> . . .the concept of Safewards is there (Interview 8)

Three of the participants identified a clear connection and identified GRiP-S sessions as an environmental agent in the change process. These participants expressed GRiP-S sessions as providing a space for nursing staff to discuss Safewards interventions within practice, and as a team to discuss its implementation within the clinical setting.

> I think because, you know, people had training at different times, the implementation of it has been a bit. . .of a process. . .so I think with that in mind it's been a good space for people to come together who aren't always on shift together or haven't been to the training sessions together to talk about it and recognise and discuss how it's helping ..and we hear peoples questions that they have (Interview 1)

> . . . if there's a patient that escalated, we will kind of talk it through, what we did and what might be, different interventions for what might be done (Interview 4)

It was acknowledged that GRiP-S sessions assisted in reducing barriers amongst the staff team towards Safewards.

> Attending the reflective practice as a group helps us. . .identify any barriers to. . .changes to practice to implement Safewards. . .I think the reflective practice sort of helps generate an understanding and enthusiasm when you're working as a group, you can identify the pros and the cons and work through it together to encourage each other (Interview 1)

> . . .some of the barriers were the talkdown tips and softwords, I think some (nurses) just found ..the choice of words (difficult).. like I say, we discuss it in reflective practice and it's easier to overcome with support from others (Interview 1)

There has also been increased awareness of Safewards interventions through GRiP-S discussions where nursing staff have assisted colleagues in identifying where and how they are implementing Safewards interventions in their practice.

> (Safewards) comes into scenarios. . .someone will come up with a scenario that's been a bit difficult. . .people then reflect what they were actually doing that related to Safewards . . . so it makes people be able to come out feeling more positive about the work we're doing, I think. (Interview 2)

> . . .(we) discuss patients and interventions, different interventions for what might be done possibly. (Interview 5)

> . . . if someone's got an issue with the patient, say why don't you try this or that, or that kind of stuff, and sure, we use the strategies of Safewards. (Interview 6)

Integrated findings

The findings show that the GRiP-S approach has a positive impact on nursing staffs' perception of clinical supervision and Safewards. Firstly, there was an improvement in nursing staffs' perception of clinical supervision post introduction of the GRiP-S approach. There was no reduction in overall MCSS-26© results. However, there remains room for improvement in clinical supervision delivery and reception with the MCSS-26© total; pre-GRIP-S- 69.54 (*SD* 16.059); post-GRIP-S 71.47 (*SD* 13.978) and yet, a mean score of 73 or higher indicates efficacious clinical supervision is being provided (Winstanley & White 2017).

The greatest shortfall within quantitative data was within the normative domain and specifically the subscale of finding time. The qualitative data mirrored this recognition that participants find it difficult to get off the ward to attend clinical supervision sessions due to ward based tasks and pressures.

The GRiP-S approach has assisted in positive change management and reduced barriers to Safewards implementation amongst nursing staff. The MCSS-26© data identified that clinical supervision sessions can be used to promote skill development. The formative domain, which includes improved care/skills, and supervisor advice/support subscales, had the highest score amongst the three domains. Interview participants recognized GRiP-S sessions as a beneficial space for staff to discuss and overcome barriers to successful implementation of Safewards as a team. This provides

improved coherence and consistency of Safewards implementation between nursing staff, irrespective of the level of training they have received, or their theoretical understanding of the model.

Participants report a positive perception and attitude towards the GRiP-S approach, while also identifying that these sessions provide a collaborative space for nursing staff to discuss their personal experience of implementing Safewards interventions within their clinical practice. Through team discussion of shared experiences and discussion in GRiP-S sessions they feel connected and supported by peers which assists in implementation of Safewards interventions.

Positive team discussions within GRiP-S sessions also improves staff buy-in of the model and ongoing implementation of the interventions in clinical practice. Some participants were able to easily identify the connection between GRiP-S sessions and Safewards, recognizing aspects of the adapted model.

DISCUSSION

The results of this study indicate that the GRiP-S approach has a positive impact on nursing staff's implementation of Safewards and clinical supervision within the mental health unit. Suggesting that the GRiP-S approach can be mutually beneficial to the individual nurse and the organization; through providing clinical supervision for the individual nurse and effective change management for the organization.

This study provides new insights into the use of group clinical supervision for positive change management within mental health nursing. Despite a significant gap in the literature, specifically on the use of clinical supervision within change management and integration of mental health nursing models of care, there is evidence to support the use of clinical supervision to sustain new practice within clinical areas (Allan *et al*. 2017; Bunyan *et al*. 2017; Butler *et al*. 2014; Jørgensen *et al*. 2019).

Historically, nursing education has embodied collaborative, supportive and governing approach to training (Cutcliffe & Sloan 2014). Oftentimes clinical supervision is viewed within a clinical governance framework and seen as a useful tool for promoting safe and effective nursing care (Bulman & Schutz 2013; Cutcliffe *et al*. 2011; White & Winstanley 2009). Research has already proven clinical supervision can enhance the wellbeing of supervisees and their professional development (Brunero & Stein-Parbury, 2008; Butterworth *et al*. 2008) and this was further identified within this study through the positive formative domain scores.

The underpinning ideology of the first two findings within this study, (i) improved therapeutic relationships and patient centred care and (ii) improved staff communication and teamwork, are supported elsewhere in literature; Australian public health bodies report that clinical supervision provides a space for deeper self-reflection on personal clinical practice through a structured approach, which can lead to care and quality improvements, and provides a space for supervisee's to develop knowledge and skills whilst building good team relationship (Government of Victoria 2018; Government of Western Australia, Drug and Alcohol Office 2013): there is also emerging evidence to suggest that secondary to improved nursing skill development, clinical supervision has a positive impact on patient outcomes (The Australian College of Midwives 2019).

The barriers identified within the study that reduced nursing staff's engagement with GRiP-S were consistent with those identified in prior research on barriers to nursing staff's engagement with clinical supervision (Brunero & Lamont 2012; Bunyan *et al*. 2017; Butler *et al*. 2014; Jørgensen *et al*. 2019). As mentioned, within this study, the time at which clinical supervision is offered can be a barrier in and of itself. Literature has identified that having supervision frequently offered at the same time and/or day limits the potential number of staff who will be available to attend, given the 24-h working pattern of ward nursing staff. It has been suggested that increased frequency and flexibility of times when supervision is offered may improve engagement (Bunyan *et al*. 2017).

Similarly, the normative issues of 'finding time' and 'internal value' placed on clinical supervision within this study have been well reported previously. Jørgensen *et al*. (2019) reports that nursing staff who are resistant to change are often more likely to avoid supervision sessions and reporting being too "busy" with more important tasks as the main excuse for non-attendance. Participants in this study consistently placed a high internal value on clinical supervision yet their external participation did not reflect this. Warrender (2016) similarly identified that due to the unpredictable nature within a mental health ward environment nursing staff often miss out on arranged supervision sessions due to a clinical incident or staffing shortages. However, often these are the pressures and incidents which need to be processed by staff and

practical solutions for improving attendance is required.

Interestingly, the quantitative data within this study identified that nursing staff generally recognized their supervisor to be trustworthy and a source of support and encouragement. This contrasts with prior research which has identified nursing staff's scepticism towards clinical supervision being based on the perception that it is a surveillance and performance management activity monitored by management (Dillon 2014; Puffett & Perkins 2017; White & Winstanley 2021).

Other recognized barriers within recent literature preventing successful implementation of clinical supervision within nursing include confusion amongst nursing staff on the various models and definitions for clinical supervision, leading to a lack of understanding on the skills required to facilitate and implement clinical supervision in practice (Masamha *et al*. 2022; White 2016). When asked about perception and engagement within clinical supervision all participants provided free-flowing responses with no consideration on confusion around what the concept constituted or the model of delivery. It may be a supposition that the structured approach to GRiP-S sessions has facilitated an understanding and expectation of the structure and format to clinical supervision delivery.

LIMITATIONS

This study had some unavoidable limitations. Specifically, the small sample size and low response rate to the post surveys. Significant missing data values of participants identification codes prevented paired analysis of individual pre and post survey data. This resulted in descriptive analysis only using cohort means to provide an overview of the quantitative data available and impacts on the generalisability of the findings.

Similarly, only participants who were interested and willing to participate in semi-structured interviews were included, increasing the risk of self-selection bias.

CONCLUSION

Safewards has been identified as an effective model for reducing incidents of conflict and containment within clinical mental health settings. It also promotes therapeutic relationships between patients and nursing staff. Delivering a clear and systematic approach to clinical supervision using the GRiP-S approach can improve staff understanding and implementation of the Safewards model. The use of GRiP-S sessions provides nursing staff with an open space to discuss their experience of this change in practice, enabling collaborative problem solving and improved team alliances.

RELEVANCE FOR CLINICAL PRACTICE

The findings of this study add to the body of knowledge on mental health nursing clinical supervision delivery and provide potential recommendations to policy and quality improvement, Safewards educational development and suggestions for improved sustainability to change of practices.

The GRiP-S approach promotes successful implementation of Safewards and clinical supervision, providing a structure and framework for mental health nursing clinical supervision sessions, which assist in reducing systematic barriers to successful implementation.

Further research into the transferability of these findings and the ongoing sustainable implementation of positive change using the GRiP-S approach is needed.

RELEVANCE STATEMENT

This manuscript outlines the initial assessment of a new and innovative approach to delivering Safewards for mental health nurses by incorporating Clinical Supervision, named GRiP-S. The GRiP-S-S approach promotes education and understanding of the Safewards model and promotes nursing staff involvement in Safewards implementation. This study assesses the effectiveness of the GRiP-S approach in delivering adequate clinical supervision from the perspective of nursing staff and its impact on promoting Safewards implementation and sustainable change of practice.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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