Safewards handbook

Training and implementation resource for Safewards in Victoria

VICTORIA State Government | Health and Human Services

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Foreword

Nurses within mental health services have driven implementation of Safewards in Victoria. It was the interest in Safewards expressed by individual services during the State-wide Reducing Restrictive Interventions Initiative that provided the initial impetus for the Department of Health and Human Services to explore the establishment of a broader Safewards trial.

The design of the trial was developed in partnership with services. Each service was responsible for implementing Safewards in their mental health units, which included adult, aged, secure extended care and youth settings.

The success of the trial and the continuing momentum in the uptake of Safewards in mental health services to date reflects the hours of work put in by staff. The growing Safewards Victoria Community of Practice is wholly organised by mental health service staff, which is evidence of the value placed on Safewards by staff engaged with implementing it.

The evaluation of the Safewards Victoria trial has found that Safewards can contribute to enhancing the culture and atmosphere in our mental health services. Staff and consumers reported that Safewards reduced conflict and improved communication. It seems that Safewards can also impact on the reduction of the use of restrictive interventions. We would like to encourage all Victorian mental health services to review the outcomes of the Safewards Victoria evaluation and consider whether implementing Safewards would help improve your local service delivery.

The department is committed to Safewards Victoria and we will continue to look for ways to support its uptake throughout the state. I invite you to connect with my office or the Safewards Victoria Community of Practice if you are interested in adopting Safewards on your ward or across your service.

I would like to thank all of the staff from the Safewards Victoria trial for their hard work and dedication to improving the delivery of mental health services in Victoria. I would like to acknowledge the role that Tessa Maguire has played in developing and running the training for Safewards Victoria, as well as being generous with her time and support. I would also like to acknowledge the contribution of the former Chief Mental Health Nurse, Tracy Beaton, in creating the opportunity for Safewards Victoria in the first place.

We hope that you find the Safewards Victoria resources useful and we look forward to hearing about your plans and progress towards implementing Safewards.

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Contents

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Alfred Health

Bendigo Health

Latrobe Regional Hospital

Melbourne Health

Mercy Health

Monash Health

Evaluation:

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Introduction

Mental health services experience high levels of conflict events such as aggression, violence and absconding. Often, in response to these events, restrictive practice may be used. Safewards is a model designed to improve the safety for everyone including mental health service staff, patients and visitors.

About the Safewards model and interventions

The model

Safewards is a model that was developed in the United Kingdom by Professor Len Bowers and colleagues. It specifically examines events known in the model as ‘conflict’ (events that threaten staff and patient safety, such as self-harm, suicide, aggression, absconding) and ‘containment’ (things staff do to prevent or reduce harm to staff and patients, such as increased observation, use of extra medication, use of restrictive interventions) (Bowers 2012).

Conflict and containment events are grouped together because:

- patients who may display one type of conflict behaviour may also display another
- different conflict and containment rates can group within wards.

Conflict and containment can vary significantly between different wards, as well nationally and internationally, and the types of containment methods can also vary significantly (Bowers 2009; Bowers et al. 2005).

The Safewards model seeks to explain the differing rates of both conflict and containment and offers interventions that are designed to reduce the risk of conflict and containment events occurring.

The Safewards model is derived from three main sources:

- an extensive literature review examining evidence related to conflict and containment within inpatient settings
- the research program led by Professor Len Bowers conducted over many years and specifically examining conflict and containment
- ‘reasoned thinking and integrative gestalt’ (Bowers et al. 2014, p. 355).

The model consists of six originating domains:

- patient community
- patient characteristics
- regulatory framework
- staff team
- physical environment
- outside hospital.

These six domains give rise to flashpoints, which are defined as ’social and psychological situations arising out of features of the originating domains, signalling and proceeding imminent conflict behaviours’ (Bowers 2014, p. 500). The flashpoints can trigger conflict, which may lead to containment, and the use of containment may also trigger conflict (Bowers 2014).

For a comprehensive description of the Safewards model go to the Safewards website <www.safewards.net>.

It is important that people are able to gain a good understanding of the Safewards model. When training, encourage participants to relate the model back to their practice by getting them to think about the factors that contribute to conflict and containment in their setting. Refresher training and the introduction of each intervention also provides an opportunity to engage people to reflect on the model and how the interventions relate to the model.

The interventions

All of the Safewards interventions have been designed to address the various flashpoints outlined in the model and to reduce conflict-originating factors. The model does not recommend the use of restrictive interventions; it ensures if restrictive interventions or containment are used, they do not lead to further conflict (Bowers, 2014).

The ten Safewards interventions are:

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

About this handbook

This handbook is designed to assist with the implementation of Safewards in your service. It contains:

- an overview of the Safewards model
- a description of the 10 interventions commonly used in association with the model
- recommended readings
- tips for education and implementation
- templates to support training and implementation of Safewards.

A series of PowerPoint materials have also been developed to support local Safewards training. These presentations are available on the Victorian Safewards website.

Other useful resources include the UK website (www.safewards.net), the international Safewards Facebook page, videos on YouTube, LinkedIn, Twitter and the Victorian Safewards Community of Practice. These provide an extensive body of material and support from people locally, nationally and internationally.

In developing this handbook, material from the UK Safewards website, from the published literature on Safewards and from policies and practice wisdom from local services implementing Safewards has been used. There has been some customisation to reflect Australian terminology.

Recommended reading

Bowers, L 2014, ‘Safewards: a new model of conflict and containment on psychiatric wards’, *Journal of Psychiatric and Mental Health Nursing*, 21, pp. 499–508.

Bowers, L, Alexander, J, Botha, M, Dack, C, James, K, Jarrett, M & Stewart, D 2014, ‘Safewards the empirical basis of the model and a critical appraisal’, *Journal of Psychiatric and Mental Health Nursing*, 21(4), pp. 354–364.

Bowers, L, Stewart, D, Papadopoulos, C. Dack, C, Ross, J, Khanom, H & Jeffery, D 2011, *Inpatient violence and aggression: a literature review*, London: Institute of Psychiatry Kings College, London.

Bowers, L, James, K, Quirk, A, SUGAR, Stewart, D & Hodsoll, J 2015, ‘Reducing conflict and containment rates on acute psychiatric wards: the Safewards cluster randomised controlled trial’, *International Journal of Nursing Studies*, 52, pp. 1412–1422.

Price, O, Burbery, P, Leonard, S-J & Doyle. M 2016, ‘Evaluation of Safewards in forensic mental health: analysis of a multicomponent intervention intended to reduce levels of conflict and containment in inpatient mental health settings’, *Mental Health Practice*, 19(8), pp. 14–21.

The Safewards website provides a description of the model in lay, easy and technical terms. The link is <**www.safewards.net/model**>.

Safewards in Victoria

Safewards trial

In March 2014, the Victorian Government committed funding to assist mental health services to reduce the use of restrictive practices. Services were required to submit Local Action Plans (LAPs) outlining strategies to reduce the use of restrictive interventions in their service. A total of seven services submitted LAPs that outlined a plan to implement Safewards. Due to the interest in Safewards, funding was sought to trial the introduction of Safewards in the seven services within Victoria. The project objectives were to:

- trial the Safewards model in Victorian mental health services using a partnership approach
- evaluate the trial
- develop recommendations for adapting Safewards for the Victorian service context to support a broader implementation of Safewards across the state
- develop resources.

The initial training was provided through three train-the-trainer workshops.

Table 1 lists the seven services and the types of wards within each service that were involved in the Victorian trial.

Table 1: Safewards Trial Services

Service	Unit Type
Albury Wodonga Health	1 x adult inpatient
Alfred Health	2 x adult inpatient
Bendigo Health Care Group	1 x adult inpatient 1 x aged inpatient 1 x Secure Extended Care Unit (SECU)
Latrobe Regional Hospital	1 x adult inpatient 1 x Secure Extended Care Unit (SECU)
Melbourne Health, NWMH	5 x adult inpatient 1 x youth acute inpatient
Mercy Health	1 x adult inpatient
Monash Health	1 x adolescent inpatient 1 x youth acute inpatient 1 x adult inpatient 1 x aged inpatient 1 x residential aged care

Evaluation of the Safewards trial

What we did

All services participated in evaluation. Data were collected across three phases, capturing a comprehensive range of perspectives, including:

- **in the training phase –** pre- and post-training surveys, train-the-trainer surveys and training and implementation diary for each service
- **in the implementation phase** - Safewards preparation checklists and fidelity checklists, focus groups with staff and consumer consultants
- **in the sustainability phase** - Safewards fidelity checklists, consumer post-implementation surveys, staff post-implementation surveys and Client Management Interface (CMI) data (routine seclusion and restraint data)

Participants in this evaluation included 72 consumers in inpatient wards, 411 nurses and colleagues in 18 wards, 29 Safewards project leads and trainers across the seven services.

What we found

Overall, the findings of the evaluation highlighted positive achievements in terms of effective implementation and ward culture change.

- The fidelity achieved by the trial sites was 6–7 out of 10 Safewards interventions over the 12-week trial period. This increased over the following nine months of the sustainability phase to **nine out of 10 interventions**, 12 months after commencing Safewards.
- **Seclusion rates in Safewards wards trended downwards** from pre-Safewards rate of 11.67 events per 1000 occupied bed days (OBD) to 7.511 after follow up (p=0.19).
- The youth wards achieved a **significant reduction in use of seclusion** from pre-Safewards to follow up compared to non-Safewards wards (a difference of 11.21 events/1000 OBD, p=0.01).
- More than **414 staff were trained** across the seven health services.
- Most staff (414+) across sites participated in central and/or local Safewards training. They made **significant gains in knowledge, confidence and motivation** to use Safewards through the training and implementation processes.

Qualitative feedback from consumers and staff highlights the culture change that took place in wards.

Consumer feedback

[Safewards was] ‘Useful and helps keep me safe and other patients calm as well.’

‘Staff have been very helpful towards me.’

‘If an inpatient you're in a dark place, these bring you back to reality, safe and hope.’

‘I think there is a real culture shift is the baseline anxiety level and fears, and that sense of threat and aggressive behaviour and all the rest of it, has really changed. And mutual help [meeting] is a big part of that.’

Staff feedback

‘Safewards basically will give you a better nurse-consumer relationship and more, it will give you safer practice, the safe practice means it will reduce the episodes, reduce seclusion, reduce physical or verbal assault.’

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

Recommendations from Safewards Trial evaluation

Recommendations for policy and governance:

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

Recommendations for future Safewards implementation processes:

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

Figure 1 Key Safewards implementation elements

People

→Senior organisational buy-in initially and intermittent engagement across the year to redress implementation barriers

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

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

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

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

Knowledge

→Strong understanding of the model and interventions within all change agents and prepared trainers

→Clear understanding of key concepts in the model in majority (>50%) of ward-based staff

→New and casual staff inducted/oriented to model and interventions

→Orientation to the model and aims among consumers and carers

→Local knowledge of outcome data, regarding conflict and containment

→Explicit processes for local adaption of training materials

Functional support

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

→Plan to fit training with existing mandatory schedule

→Dedicated budget for intervention items, plan for replenishing

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

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

→Organisational link to another Safewards site

Key personnel can use this model as a resource throughout implementation of Safewards.

Recommended reading

Hamilton, B 2015, ‘Evaluating Safewards in Victoria’ *Carillon*, 17(59), pp. 1–2.

Hamilton, B, Fletcher, J, Sands N, Roper, C & Elsom, S 2016, *Safewards Victorian trial final report*, Centre for Psychiatric Nursing, Melbourne.

Victorian Safewards Community of Practice

The Victorian Safewards Community of Practice (CoP) was established in April 2015 to assist the implementation and sustainability of the Safewards model in Victoria. The role and purpose of the CoP is to support services embarking on the Safewards journey by sharing knowledge and resources.

Membership is by way of invitation from the CoP, and membership is inclusive of any service considering or currently implementing Safewards in Victoria. The CoP also has representation from the Office of the Chief Mental Health Nurse from the Department of Health and Human Services as well as Melbourne University. Each service involved in the CoP is required to nominate representatives who can attend and participate in the CoP meetings. These representatives are responsible for reporting and sharing information about the CoP back to their organisation.

The responsibilities of the CoP include fostering communication and collaboration, providing leadership to other services in regards to the implementation of Safewards, and promoting Safewards to other services. The CoP meets quarterly and in between meetings members are kept up to date and share information via email.

If anyone in your service is interested in becoming a member of the Victorian Safewards CoP, contact the Office of the Chief Mental Health Nurse of Victoria for the contact details of CoP coordinators.

Community of practice attendees in August 2016

Before Safewards training and implementation – things to consider

Before introducing Safewards to your unit, there are some things worth considering.

Support of executive, staff, consumers and patients

The support of hospital executive is essential in the implementation process in terms of assisting the allocation of resources, demonstrating leadership, commitment and support for Safewards, monitoring progress and embedding Safewards into hospital programs.

Along with support from the hospital executive, according to the Safewards evaluation in Victoria, other key elements that enhanced implementation included the engagement of a leader and key group of staff who are positive and supportive of the Safewards model, prominent involvement of the Safewards lead and nurse educators, and use of existing processes to support implementation (and introducing new processes if needed).

The involvement of consumer consultants and patients on the ward is also a key element that can assist engagement and enhance the implementation process.

Before training and implementation

- Familiarise yourself with the model and interventions.
- Write a project plan for the implementation of Safewards. The appendices provide resources to assist in planning (Appendix 1 Safewards project plan template, Appendix 2 Safewards preparation checklist and Appendix 4 Safewards implementation planning).
- It is helpful to set up a governance structure to monitor and lead the implementation of Safewards. Identify and engage key stakeholders early in the process.
- Consider how you will evaluate the introduction of Safewards as part of the planning process. Refer to the DHHS Safewards website section on evaluation methods and the evaluation report from the Safewards Victorian trial (available on DHHS website).
- Consider the order that you will introduce the interventions; for example, if you are planning to stage interventions, which will you introduce first and why? It can be beneficial to get some early gains by introducing interventions that will make a big impact from the start (such as know each other, which engages patients and staff and can be visually appealing on the ward). Appendix 3 Intervention summary, resources and roles outlines may assist in this process.
- Consider common conflict and containment issues in the wards you are about to deliver the training. Draw these issues out in the training to engage people in thinking about how they can make a difference on their ward.
- Consider who might be suitable as intervention leads before the training. If you can identify people and inform them before the training this can help them think about the intervention during the training.
- Consider people's roles and the influence they can have on the interventions (for example, with positive words consider who is going to be in most handovers or who can best influence existing challenges to this intervention).

Training delivery options

There are many options available for training. Resources have been developed, available through the Department of Health and Human Services, to support three comprehensive training formats and refresher training.

- Train-the-trainer

  The initial training in the Victorian Safewards trial consisted of a three-day train-the-trainer approach. This model was designed to provide educators with a comprehensive understanding of the model and interventions, and with a range of activities to use to engage staff in their organisation during the training.
- Two-day workshop

  The two-day workshop covers the model and five interventions on the first day. The second day of the workshop starts with a revision of day one then focuses on the remaining five interventions.
- One-day workshop

  The one-day workshop covers the model and the 10 interventions. The order of the interventions has been designed to flow effectively and alternate between straightforward and more complex interventions. However, you may choose to change the order as you see fit.
- Refresher training

  The refresher training offers a range of activities designed to reinforce the key points of the Safewards model and interventions. You can choose activities from the PowerPoint slides. The refreshers can also be used for brief training at handover and in the workshop training. It is strongly recommended that any refresher training starts with a revision of the model.

A range of training resources are available on the Department of Health and Human Services Safewards website to complement your presentation. These include the PowerPoint presentations and a suite of videos. The videos include an introduction to the model and the 10 interventions. The videos can be used for self-directed learning or can be incorporated into the presentation.

All of the PowerPoint presentations have been designed so you can include or remove activities to best suit your audience. The Safewards model refresher has several activities to choose from, depending on your audience and training needs.

During the training

- Ask participants to fill out the implementation plans at the workshops/training (see Appendix 5 Safewards intervention implementation plans).
- Consider using the Safewards videos (on the Safewards website) to reinforce your teaching points.
- Engage participants by using examples from your own practice and area of work.

After the training

- Collate the implementation plans and send them to intervention leads and participants to assist them with implementation.
- The Safewards CoP might be a useful forum for the intervention leads to attend for support, information gathering and networking with other intervention leads.
- Consider focusing on a different intervention each month. Use the intervention refresher slides to provide education and to check you are on track with the intervention.

The Safewards interventions

The following sections describe each of the 10 Safewards interventions, providing a brief background, a description of the intervention and the role of the intervention lead, as well as examples of how the intervention has been implemented in Victoria.

The 10 interventions are:

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

The following Safewards interventions have been adapted from the Safewards website at <www.safewards.net>.

Know each other

Background

It is often said that the foundation of mental health practice is the formation of good, therapeutic relationships with patients. We all know this is very important; however, forming relationships with patients on an acute ward has specific challenges. The rostering shift system impacts, as does the high turnover of patients, the pace of admissions and discharges, the amount of routine work to do, the filling out of forms, the phone calls, the ward rounds and so on.

When we talk to patients, it helps to know their background and interests – this give us conversation topics we can raise, as well as information we can share with the team so that everyone can engage the patient. It provides an insight into the person we are working with and shows a willingness to get to know what a person likes, knows and thinks.

The same thing can work in reverse. If patients are given a little more information about staff, they can find areas of common interest and conversational topics. The mutual familiarity and knowledge can help us form relationships faster, which can assist with orientating patients, enhance their coping skills, ameliorate more difficult behaviour, and help them feel more comfortable and reassured during admission.

While we collect lots of information about patients on admission, little of it provides a basis for relationship building, chatting and general friendliness. It also tends to be negatively focused on a psychiatry history of illness, disorders, disabilities and admissions. This intervention seeks to rectify or counterbalance that by collecting social information that gives a picture of the person, their activities and interests.

By collecting information that provides the basis for relationship building and making this information publicly available, this intervention aims to facilitate conversations and enhance relationship building between patients, and between patients and staff, making conflict less likely.

Description

The know each other intervention focuses on providing and sharing information that can help staff and patients know each other better and form positive relationships.

Staff information

Each staff member will provide non-controversial information about themselves that they are happy to have communicated to patients and staff. This could include their qualifications, years of experience in mental health, hospitals or places they have worked, previous jobs, hobbies and interests, favourite TV programs, films and books (with reasons), preferred music genre, top life tips (other suggestions are welcome).

The information will be printed on a single laminated sheet, which is placed in a ‘know each other folder’. The folder or chosen format will be made available to patients. When staff leave the ward to work elsewhere they can take their sheet with them or have it disposed of as per hospital policy.

Patient information

On admission, if the patient is willing, staff can ask the patient and their carers questions that help produce a profile that describes who they are as a person. The information collected can include key background information, such as their likes, dislikes, favourite things, quotes, beliefs (visitors of the patient can add to this profile as well if the patient consents). Staff can refer to this profile to get to know their patients better and to serve as conversation triggers. The profile can be accompanied by a graphic or picture of the patient’s choice.

The patient profile could include favourite type of music and musical instrument they play; fashion and dress style; favourite films, TV programs, TV channels, websites and radio stations; favourite sports and teams; favourite foods and drinks; favourite books, magazines and newspapers; hobbies and interests; current and past work; favourite places, countries they have visited, holiday spots; favourite animals and pets; favourite actors or actresses; their best friends and role models, famous people they would like to meet or have met; proudest moments and greatest achievements; their special skills, such as in music and art, and the leisure activities they enjoy.

The patient information may be added to the know each other folder (with consent). On discharge the patient can either take the sheet with them or choose to have it disposed of as per hospital policy.

Role of the intervention leads

- To lead in collecting the background information from staff and patients, printing and laminating the sheets.
- To draw the attention of patients and staff to the information.
- To make sure the know each other folder (or information in the chosen form) stays out on the ward.
- To replace profile sheets that get lost or mislaid.

Local examples

- During the training, use examples of the know each other forms filled out by people who are known to the workshop attendees (for example a person who visits the wards frequently, a person who staff frequently receive emails from but may not necessarily know well).
- Ask some key people in the workplace to complete a know each other form, such as the CEO, Clinical Director, Director of Nursing.
- Encourage a wide range of people to complete a know each other form, for example community visitors or people from external agencies who frequently visit the ward.
- Display the know each other sheets around the unit in places accessible to the patients, such as high traffic areas, or have a rolling display on an electronic device such as a monitor that can transition through the various know each other forms throughout the day.

Clear mutual expectations

Background

Some of the difficult and challenging behaviours exhibited by patients are due in part to a lack of clarity about how they are expected to behave, or a lack of consistency between the ward staff about what the expectations are. This ambiguity or lack of clarity is particularly problematic for people who may:

- have difficulty thinking clearly
- be distracted by psychotic thinking or preoccupations
- find it hard to concentrate
- have difficulty interpreting the verbal and non-verbal communications of others
- be undergoing extreme emotional distress and changes to their mood, which may result in bias of their perception and interpretation of what is going on around them
- have a distorted view of the world and others, particularly those in positions of authority, possibly due to past experience and upbringing.

These expectations work both ways; just as the staff have expectations of patients, patients have expectations of the staff.

Clarifying expectations allows the staff to be consistent and everyone to understand their obligations. Communication between everyone will be eased, and clarity in the social environment will help patients think more clearly and experience less irritation and frustration. Lowered stress and anxiety help to reduce symptoms and aid patient recovery.

As patients find the word ‘rules’ infantilising and objectionable, it is more effective to talk about expectations, guidelines or standards.

Description

Clear mutual expectations need to be established in consultation with staff and patients. The following is a recommended process for establishing and promoting clear mutual expectations.

Step 1: At a staff meeting, discuss the skeleton list of mutual expectations. Decide which of the expectations the staff feel should be included, what should be added, and what should be changed and how. Staff should also consider if some rules are trivial or unnecessary – for example, limits around when hot drinks are available. Ask each other ‘who are we to say “no”?’

Step 2: Hold a community meeting with the staff and patients, circulate the list of suggestions, and agree with the patients present what should be included in the expectations of staff and patients, as well as which are the most important. Ask for additional suggestions; there may be areas or topics patients would like to clarify that have not been raised yet. Be prepared to:

- share the true reasons for these expectations with the patients
- identify which expectations are required by the hospital or the managers
- explain to patients how they can appeal or ask to get such requirements changed.

At the close of the meeting, agree on the final list and contents and choose a design format for these to be printed. You could modify or work from one of the examples provided on the Safewards website.

Please note: you may need to repeat steps 1 and 2 to ensure you include a wide range of patient and staff views. It is recommended the consumer and carer consultant for the ward participates in this process.

Step 3: Type up your agreed list of mutual expectations. You can design a new format (we recommend using PowerPoint) or use an example from the Safewards website and replace it with the mutual expectations agreed on with your staff and patients.

Step 4: Print the mutual expectations and have them laminated as a poster. Hang the poster in a prominent public space where patients and staff can read it. Some wards choose to have more than one copy. Smaller copies can be placed in patient bedrooms or included in welcome packs.

Step 5: Make the poster part of the admission process. Go though it with new patients, perhaps several times over the first week to make sure they understand the contents.

Step 6: Refer to the expectations when asking patients to desist from certain behaviours or when asking them to do something.

Step 7: Encourage patients to refer to these expectations with staff when they fail to uphold them.

Before implementing this intervention:

- identify a printer that can print and laminate the poster
- identify how this will be paid for.

Mutual expectations for consideration

The following are sample expectations to consider for your service.

General expectations

Expectation	Rationale
We are all here to help and support each other.	If we help and support each other, patients will get better faster and be able to go home sooner.
We can all expect to be treated with respect by each other. Patients can expect that the staff will be polite and respectful to them and that other patients will also be respectful. Verbal abuse, threats, racist or homophobic comments, bullying and violence have no place on our ward. Being very noisy, shouting or making others uncomfortable in any way should be avoided.	Everybody is a human being with equal rights. A calm and safe ward lowers stress and helps people get better faster.
We can all expect others to be tolerant of our behaviour when we are ill, and be patient with us.	When unwell, we can behave in ways that are troublesome, distressing and irritating to those around us. Even when we are not unwell it can be difficult to live with others who have different habits and ways of life. We all are human beings and we all make mistakes from time to time. If we are tolerant and understanding towards others we can expect others to be tolerant of us.
Everybody needs to look after themselves, keeping themselves clean, well dressed and assisting to keep the ward clean and tidy.	So we look good to each other, generate a positive and hopeful atmosphere for everyone, and don't make others uncomfortable due to odour or wearing dirty clothes.
Neither staff nor patients will leave the ward without permission.	Staff are obliged to be present and available to care for patients during their working hours. While everyone should have the maximum liberty they can, in some cases it is not safe for patients to leave the ward while they are unwell, or there are legal reasons why they cannot do so.
Patients are encouraged to participate with their agreed treatment plan by attending group activities and therapy sessions, taking agreed medications, and helping each other by encouraging and supporting each other to do the same.	Participation speeds recovery and discharge and helps other patients who may find it difficult to be motivated or participate.

The staff

Expectation	Rationale
The staff will respond to patients' requests in a timely and efficient way, reporting back to patients on progress.	To do this expresses care of, and commitment to, patients. Patients who know the staff are committed to them have a better therapeutic relationship with the hospital and treating team and are more likely to cooperate with treatment, thus getting better faster.
The nurses, staff and clinicians will be as accessible and available to patients as possible.	Being available to patients means that patients will not have to behave in extreme ways to get our attention. It also expresses respect for them and shows a caring attitude.
Clinicians will follow their professional code of conduct: treating patients as individuals, respecting confidentiality, collaborating with patients, gaining their consent, maintaining clear professional boundaries, working as a team, providing the highest standard of care, and acting with honesty and integrity.	Because anything else would be wrong, harmful to patients or exploitative.
The staff will follow hospital policies in caring for patients.	Hospital policies are best care practices as judged by professional leaders in the hospital with reference to best practice standards and guidelines.
The staff will act in accord with the *Mental Health Act 2014*. This means keeping patients fully informed of their rights and assisting them with any appeal process. It also may mean keeping some patients at some times on the ward, or insisting on the acceptance of treatment.	This is our legal and professional duty, as agreed by the treating team.

Excluded items

Expectation	Rationale
Neither the patients nor the staff will bring drugs or alcohol onto the ward, consume them there or give them to another patient for them to consume.	For staff this means they would not be able to do their job reliably and properly. For patients this interacts with their medications, makes it difficult for anyone to know whether the prescribed medications they are taking are doing them any good, and may make their illness worse or their recovery longer. For both patients and staff, drugs and alcohol make disrespectful and difficult behaviour more likely, may have damaging effects on physical health, and may create dependency and addiction.
We ask that patients do not bring any of the following items onto the ward: scissors, knives, razors/blades, medications not provided by the staff, plastic bags, lighters/matches, and weapons of any sort or whatever else applies on your ward.	Unwell people can at times be extremely distressed and upset to the point of wishing to harm themselves. To reduce the risk of this happening, there are certain things that should not be available, either as part of people's own property or as the property of others. To safeguard everybody, we ask that no one brings these into the ward.
We ask everyone not to smoke on the ward.	It is unhealthy, bad for us and is prohibited by law.

Property

Expectation	Rationale
We will all respect each other's property, not taking or borrowing anything without permission, not damaging anything belonging to anyone else, including the ward fabric, furniture, fittings and equipment.	Respecting others includes respecting their property, their rights, the place where they are living and the shared costs of running our hospital.

Places

Expectation	Rationale
Male patients are asked not to go into female wings or bedrooms (and vice versa).	Because patients are unwell, sometimes vulnerable and not necessarily in a stable psychological condition, we all have to protect each other and respect each other's space.
All patients are asked not to go into [list areas relevant to your ward].	Usually there is a safety reason for such restrictions. Are you able to say what it is in your ward?

When these expectations are not fulfilled, patients can;

- talk to the staff
- make a formal complaint
- access consumer services.

Role of the intervention leads

- To ensure that the mutual expectations meetings occur, communicate the results to the patients and staff, approve proof copies of the poster and ensure they are hung in appropriate places on the ward.
- If you are the admitting nurse, introduce the poster to the patient and explain the contents. If you are on duty when a patient is admitted, remind the admitting nurse to do the same.
- If you are at a handover and a newly admitted patient is described, ask whether the poster has been introduced and explained.

Local examples

- Debunk myths about what staff can and cannot do before implementing clear mutual expectations.
- Laminate each of the clear mutual expectation points separately so they can be displayed throughout the unit.
- Place copies of the clear mutual expectations in patients' bedrooms or in admission packs.
- Display the clear mutual expectations on a monitor.

Mutual help meeting

Background

The ward as a social community should not be ignored as this is a powerful mechanism to help patients shape behaviours and progress towards discharge. The assistance that patients give each other is highly valued by them. Giving help, even in the most minor of respects between patients, offers the giver a socially valued role, the chance to make a meaningful contribution and the potential to increase their self-esteem. Furthermore, about half of all patient violence arises from patient behaviour or patient-patient interaction.

By supporting people to positively appreciate each other, contain their own emotional reactions to each other's behaviour and uphold behavioural expectations, this intervention contributes to reduced levels of conflict.

Description

A mutual help meeting is a voluntary meeting of all patients and staff on duty. The meeting should be held first thing in the morning and, preferably, every day (certainly no less than three times a week). The more often the mutual help meeting is held, the shorter the meeting can be.

The meeting focuses on how everyone can help each other during the rest of the day. It follows a structured agenda and when all the points in the agenda are covered, the meeting can be closed. The meeting does not have to be chaired by a staff member. The agenda points can be incorporated into other ward meetings for all patients and staff if required.

Specific staff roles:

- Prepare examples or suggestions of how people could contribute and report in advance of the meeting.
- Ensure the agenda is covered in full and everyone has a chance to speak in the meeting.
- Offer suggestions on how patients could help each other when they cannot generate ideas, thinking of even small things such as words of encouragement.
- Guide the expression of mutual respect and positive appreciation between patients and help them understand each other's behaviour.
- Provide an accurate description of any recent potentially distressing events on the ward.

General staff roles:

- Prepare the room and assemble patients and staff.
- Keep the meeting directed to its task and stop it from drifting off or being interrupted.
- Encourage good contributions through positive feedback.
- Reframe negative contributions so they become positive.
- Listen and be attentive.
- Model mutual respect.
- Enable everyone to contribute.
- Give information and seek information and opinions.
- Clarify and summarise for others, suggest compromises and settlements.
- Limit the over-talkative and draw out the quiet.

Getting organised for the mutual help meeting

Agree, as a ward, when and where the mutual help meeting will be held to fit within the existing ward routine. Agree on a start date and inform all the staff on the ward who need to be informed about the meeting and their role in holding it. If the ward has a diary, enter meeting times in the diary as a reminder. If the ward has an activity timetable, advertise the meeting on the timetable.

Convening patients for the meeting may be difficult at first. The Safewards website provides a leaflet *Patient leaflet for Mutual Help Meeting* that outlines what the mutual help meeting is about. Explain what the meeting is for, how it will benefit them and solicit their support. Expect only a few to say yes and participate for the first few weeks; however, attendance should grow modestly as the meeting is held regularly and patients talk to each other about it. Even with a few people at the meeting, it can still be very productive. Those who are present can consider how they can help others who are not attending, as well as help each other. Even small things can be very important to people.

The agenda

The agenda should include the following four items:

Round of thanks: Everyone (patients and staff, going round the room one by one) has the chance to thank anyone (patient or staff, present or not) for anything they have done for them since the last meeting. Nothing is too small to mention and everyone is free to comment once someone has made a contribution.

Round of news: Staff explains recent events or incidents on the ward that might be confusing or distressing. Assist the ward community to psychologically understand each other's behaviour (drawing on the Safewards handout, *Understanding unsafe and risky patient behaviours*) or to understand the reasons why staff act the way they do. Remind everybody what is going to happen today or over the next few days. Finally, ask everyone to watch over each other and keep each other safe, and to contact the staff for help if they are worried about another patient.

Round of suggestions: Everyone has a chance to offer suggestions as to how we can get along with each other over the next period, without becoming angry or losing our temper.

Round of requests and offers: Everyone has a chance to say how others in the ward community can help or assist them over the next period. When requests are made, anyone is free to offer to fulfil them. When everyone has had their say, the meeting considers how to help those patients who have not felt able to attend.

When these four rounds are complete, the meeting is closed.

Examples of requests and offers

- Share knowledge and experience about care and services.
- Support each other in practical tasks (for example, help others to wash their clothes).
- Encourage each other to take part in structured activities or go along to encourage and assist them.
- Wake people up so that they can attend activity groups.
- Accompany each other on walks or trips outside of the ward.
- Play games with each other, such as cards or table tennis, or discuss current affairs.
- Spend time with people, just talking to them, maybe just five minutes during a day or maybe more.
- Share coping strategies, such as relaxation techniques.
- Make a drink for someone else.
- Sit next to someone at meal times.
- Say good morning; ask how someone else is feeling.
- Orient someone, confirm where they are, what time of day it is, who other people are on the ward.
- Help someone comb or brush their hair.
- Listen to music with someone or watch a TV program together and talk about it afterwards.

- Find positive things to say about someone's appearance, behaviour or other characteristics.

Role of the intervention leads

All staff are leads for this intervention and share the following roles:

- To chair the first meeting and explain to all what it is about and for.
- To make themselves available to attend these meetings as a priority.

Local examples

- Advertise the mutual help meeting in a Safewards newsletter that is designed for patients on the ward. The newsletter can also be used to share information about the purpose and agenda of the meeting.
- Ensure that the minutes of the meeting are kept in a location for staff and patients to read and allocate staff to action or follow up items that may require assistance.
- If your ward has an activity nurse (or similar role) ask that they place the mutual help meeting on the timetable and assist in supporting the patients with this intervention.
- Hold a mutual help meeting in the afternoon; this can help set the tone for the afternoon and also help in following up anything from the morning meeting.
- Hold a mutual help meeting on the weekend.
- Apply the principles of mutual help meeting to a nurses/staff meeting. This may help others see how effective this intervention can be in practice.

Calm down methods

Background

Sometimes we can recognise early signs of agitation. It might be someone's facial expression, tone of voice, quick response to a common reminder, restlessness, change of breathing pattern, body language, eye contact (or lack thereof), movement around the ward or other cues. Pro re nata (PRN) medication has been used as an effective strategy to calm people down, but perhaps we reach for it too easily and too quickly on occasions. At times it is effective to use the person's own strengths and usual coping mechanisms to help them calm down.

This intervention suggests a range of alternatives to using PRN medication and provides the means to make these items available to people where possible.

Description

This intervention is about collecting and making accessible a range of items and equipment that can be used to help people calm down.

Assemble a box of 'calm down' equipment for your ward. Your equipment may include:

- hot or cold scented towels
- relaxing music (iPods with classical, chill out and new age relaxation music)
- letter writing kit
- face masks and ear plugs (so people can have a nap/break from the ward)
- stress balls
- hand massage kit (instruction card and oils)
- massage balls
- personal fan
- rainbow light projector
- cuddly toys
- herbal tea
- chewing gum
- blankets with different thicknesses and textures.

When a person appears to be tense, agitated or showing other known indicators that they may become angry and aggressive, offer these calm down methods before considering PRN medication.

All items listed above were independently checked for suitability by two experienced occupational therapists in the UK as part of the Safewards program.

Other calm down methods you could use include:

- cold drink/hot drink/milky drink
- snack (carbohydrates: toast/biscuits/chocolate)
- 15 minutes with staff engaging in an activity
- going for a walk outside ward or in garden/courtyard
- watching TV
- reading poetry
- talking to other patients
- distraction, such as playing video games, table games, cards, Scrabble
- calling family or friends by phone
- doing artwork

- time in room or quiet area
- bath or shower
- exercise, jogging laps, press ups and so on, with or without nursing staff accompaniment
- relaxation and deep breathing exercises (nurses can talk these through, and practice with the patient)
- picture books
- holding and feeling things with different textures
- bubble wrap to pop.

In Victoria, some popular and useful calm down items have included:

- weighted blankets
- music on devices such as iPods
- herbal teas
- soft balls and stress balls
- hand held massage devices.

Role of the intervention leads

- Suggest the use of calm down methods and sensory modulation to assist people when they are showing signs of distress.
- Enquire if calm down methods have been used when people are identified as agitated or if PRN medications were used and are mentioned at handover.
- Check the calm down box regularly and make sure items are in good order, clean and working.
- Secure replacements for missing, depleted or broken items or initiate the process for this to occur.

Local examples

- Include the calm down box on the orientation checklist so staff and patients are introduced to the items and the purpose of this intervention during orientation.
- Download music from a range of genres and place them into specific folders for people to select from.

Bad news mitigation

Background

Research conducted by Professor Bowers and his colleagues examining absconding found that some patients leave impulsively and in anger following unwelcome news. Approximately one in four people who absconded left in anger at their treatment. Some of the people interviewed in the research described long-term dissatisfaction with psychiatry, while others left impulsively following unwelcome events, such as refused requests for leave or discharge or negative outcomes at Mental Health Tribunal hearings.

The Safewards researchers suggest that ‘perhaps we don't always realise how emotive and how important it is to the patient to get a positive response to their requests’. To the staff, refusal may appear to be no more than a ‘trivial delay in the patient's orderly progression towards discharge’ (www.safewards.net). To the patient, emotionally and practically, this might be considered a disaster – a crisis that may be further complicated and exacerbated by symptoms of their illness and magnified and renewed by the restrictions placed upon them while in hospital. The opportunity for people to have a different experience of bad news by a delivery that encompasses a compassionate and caring response may result in less isolation or distress.

Bad news from home can also precipitate distress and conflict for patients. Severe examples would be a death in the family or the termination of a relationship with an intimate partner. Other examples of bad news might include the loss of tenancy, a burglary, illness in the family, childcare issues, all of which can be a source of stress and concern for patients. The resulting stress and distress can result in individual presentations on the ward that may include increased irritability, aggression, violent incidents and absconding.

The purpose of this intervention is to help us notice occasions when people may have received bad news (or identify potential occasions in advance) and act fast to mobilise psychological and social support for the person, before the distress turns into a conflict incident.

Description

Bad news mitigation focuses on being aware of events that might generate angry or upset responses and being prepared to respond in a way that helps avoid distress.

In each handover, discuss as a team the issue of bad news and share knowledge about people on the ward in order to predict who might receive unwelcome news and how support will be offered. Work with the multidisciplinary team in the ward round, ensuring that time, empathy and responsiveness are fundamental to the delivery of bad news. If this does not occur and the person receives a call or news from home, make sure you engage with the person to offer support and care after it has happened.

Be aware of what is going on for people through regular engagement with them and knowing their general demeanour. If there are small signs of distress, upset or unhappiness, engage with patients, particularly after they have received phone calls or a visit.

Find a quiet place and give the person time to express their feelings. Acknowledge their frustration, express sympathy and empathy; perhaps make a friendly gesture like providing a cup of tea or snack.

Answer any questions honestly, giving the person time, attention and respect. Show that you are receptive to their concerns through some simple listening techniques such as making eye contact, asking about their concerns, and using open-ended questions, such as ‘tell me more about that’.

It is important to find out how much the person understands about recent care decisions; this will allow you to correct any misconceptions they have and reframe their treatment in a positive way. The person may not be able to absorb all the information they have been given at the ward round. Following up is a good way to assess their emotional state and understanding of the situation.

Shock and anger accompanying bad news can create confusion or hinder understanding in anyone. This may be compounded by the person's illness or medication. Making sure the person understands the decision and acknowledging their feelings can improve the relationship and will make aggression, self-harm or absconding less likely. Asking someone to understand the decision is not the same as them not agreeing with the decision; treating teams and clinicians should be responsive and respectful of the person's view if it differs from their view.

Role of the intervention leads

To make sure two questions are considered by the team at handover:

- Has any patient received any bad news over the past shift and, if they have, how can we support them?
- Is anyone likely to receive bad news during the coming shift and, if so, how are we going to manage that?

See Appendix 7 for handover prompts.

Local examples

- One service used specific examples from their ward of different types of bad news patients had received. They outlined the bad news scenario and then asked staff to consider how they would deliver the news using the principles of bad news mitigation. After staff discussed how they would deliver the news using bad news mitigation, they discussed how it actually occurred in practice and highlighted the advantages of using bad news mitigation.
- Ensure there is consideration that bad news consists of many forms; what may not be considered bad news by someone, may be considered bad news by another person. Tease this issue out in refresher training.
- Consider including bad news mitigation in trauma informed care training.
- Hold an in-service with the medical team about bad news mitigation.
- Have a system in place to alert the team when a person may receive bad news (such as a prompt on a handover sheet).

Recommended reading

Bowers, L. Jarrett, M. Clark, N. Kiyimba, F & McFarlane, L 2000, 'Determinants of absconding by patients on acute psychiatric wards', *Journal of Advanced Nursing*, 32(3), pp. 644–649.

Bowers, L. Alexander, J. Gaskell, M. A & Gaskell, C 2003, 'A trial of an anti-absconding intervention in acute psychiatric wards', *Journal of Psychiatric and Mental Health Nursing*, (10), pp. 410–416.

Soft words

Background

When a person is acutely ill, their behaviour can be very difficult to understand and contain. Part of the care given by the treating team is to make sure when people are affected by delusions, hallucinations, overactivity, agitation and distress that they are able to get sufficient sleep, get up in the morning, wash and attend to personal grooming, wear appropriate clothes, eat and drink sufficiently, and so on. In addition, efforts should be made to build a therapeutic relationship, foster social contact between patients, and engage people in organised and meaningful activities.

At the same time, nurses have to ensure that they administer prescribed medication, that people don't leave the ward without permission and that they attend their appointments with professionals. Nurses also have to avert or diffuse arguments between patients and prevent people from harming themselves. Often this is in the context of patients being formally detained in hospital under the *Mental Health Act 2014*, not understanding they are ill and maybe not wanting to be on the ward at all.

It is, therefore, no wonder that a primary flashpoint leading to violent incidents is limit setting. Whenever nurses and other staff have to respond to patient requests, ask patients to do something (or stop them from doing something), this can give rise to frustration and wounded feelings. After limit setting, people can feel humiliated, disrespected and treated like children. Occasionally their response can escalate into verbal abuse or even physical violence.

This intervention provides ways to avoid confrontations and work more collaboratively with patients.

Description

Soft words is communicated to the team in the following ways:

1. Place a 'message of the day' poster displaying soft words tips in the ward office and change it regularly, preferably daily.
2. Provide postcards with special hints and messages in an interesting format as a booster.

The following are some suggestions relating to the use of soft words on your ward.

Be respectful and polite

- Be polite and respectful; for example, say 'please' and 'thank you'. Any lack of respect, real or implied, can give rise to a flashpoint, which may result in conflict or containment.
- Let your whole manner express genuine respect, empathy and warmth for the patient as an equal. Verbally show your understanding of how frustrating or difficult this might be for the patient. Show empathy for their viewpoint.
- Don't stand over people; work at eye level if needed (to decrease the likelihood of body language being interpreted as authoritarian or disrespectful). Refrain from finger wagging, frowning, looking down your nose, folded arms, narrowed eyes and so on.
- Don't be critical, hostile, angry or frustrated, as this provokes resistance and opposition.
- Don't shout, threaten, belittle, criticise or demean the patient in any way, overtly, by implication from your choice of words or by body language.
- Be an effective role model. Demonstrate how to work within a set of rules and constraints that you do not necessarily agree with, but still adhere to in a mature manner. Show this in the way you respond to requests from the person in charge.

Turning down a request from a patient

- Pay attention, listen and hear the person's request and the reasons and feelings behind it. Seek a complete understanding and check that with the person, if needed. Don't ignore the request or pretend you haven't heard it.
- Your first reflex should be to say 'yes', not 'no'. Do you really need to say 'no'? Can you justify saying 'no'? Is this something that with a bit of effort or checking you could say 'yes' or at least a partial 'yes' to?
- If you are not in a position to make a decision, agree to refer the matter on to someone who can and agree on a time frame by which they should hear back with the outcome. Then make sure it happens.
- Avoid an outright 'no'. Offer options and alternatives, rather than a complete denial. This will help the patient feel that they are not completely denied and that staff are willing to listen and help them.
- Don't say 'I can't do anything', 'It's not my problem', 'He/she isn't here', 'You must be mistaken', 'Calm down' or 'Don't shout'.
- Explain in detail and with good reason why you cannot give them exactly what they want.
- Apologise for the fact you can't give them exactly what they want.
- Don't make promises you can't keep. If you do make promises or commitments, make sure they are fulfilled or go back to the patient and explain why they can't be. Don't forget!
- Admit fallibility. Agree that you may be wrong or that the constraints and rules might not always apply in ways people feel comfortable.
- Explain to the patient how they can appeal or complain about the decision and offer to assist them with doing that if they wish.

Asking a patient to do something

- Consider first if what you are asking is too much to expect of the patient or too difficult for them to do by themselves. If so, reduce the expectation or offer assistance.
- Suggest, don't order. Suggesting is better than dispensing orders; it helps staff elicit cooperation and helps to develop the relationship with the patient. Say, 'Do you want to…', 'would you like to…', 'this is what people usually do'.
- Give reasons. Explain why the task is important, what will be achieved by doing it and how that will help the person restore a normal pattern of activities and shape to their day.
- Be flexible. Talk about the task. Explore the patient's point of view so they can feel heard and valued. If possible, adjust the timing or content of the task to suit their wishes. Understand the blocking factors and find a workable compromise.
- Break tasks into small steps. This makes it easier for people to understand what is required and to succeed at what they are trying to do.
- Avoid, defer or postpone tasks. Choose the right time to ask, for example, when they are not especially agitated, irritable, tired or upset.
- Maximise task choice and attractiveness. Give the person choices about when and how the task can be accomplished.
- Prompt. Stay with the person while the task is being completed. Give gentle reminders and prompts (form of coaching: 'shall we do this now').
- Give positive feedback and encouragement. Acknowledge people's efforts. Praise and gratitude can keep people motivated to complete the task.

Asking a patient to stop doing something

- If the person is doing something that is trivial or is likely to resolve as the patient gets better, choose to address the issue at a later time. However, do not allow this to become repetitive avoidance of confronting a person whose behaviour might be frightening, otherwise a double standard will develop, which could make other patients angry and upset.

- Discuss the issue later. Discuss at handover or ward round and agree on how to respond if the behaviour recurs.
- Distract. Stop the behaviour by involving the patient in something else entirely that is incompatible with the undesirable behaviour.
- Ask, don't order. You are more likely to get cooperation and avoid a power struggle. Do everything to avoid insistence or a show of force.
- Explain why the person needs to stop, give reasons and explain the advantages of stopping. Never say things like: 'because it is the rule here' or 'because I say so' or 'because I'm in charge here and you have to do what I say'. Don't even think them!
- Give them time to change their mind unobserved (so they can avoid a public climb down). Let them decide in their own time.
- Try another nurse. Maybe someone else can succeed in following your preparatory work.
- Give up. It is not necessary to win every time. The ward and the leadership and responsibility of the staff will not collapse so easily. Sometimes it is better to give up than have a major, excessive confrontation. Not always, not regularly, just sometimes.
- Respect people's privacy. Discuss the behaviour privately with the person, not in front of an audience (if that is possible), as then pride will not get in the way of compliance.
- Admit fallibility. Agree that you may be wrong or that the constraints and rules might not always apply in ways people feel comfortable.
- Explain to the person how they can appeal or complain about the decision, and offer to assist them with doing that if they wish.
- Offer a reward or quid pro quo: 'If you can see your way to doing this, then we can …'. Ask the patient 'Is there anything I could say that could get you to go along with? I'd like to think there is'. The goal is to generate voluntary compliance.
- Find alternatives. Seek to understand the behaviour and what need it expresses. Offer to meet that need for the patient in a different way.
- Be flexible. It isn't always necessary for the patient to do exactly what you tell them to do.
- Let them have the last word. As long as they are moving towards compliance, it's OK if they pass a comment. Let the person save face whenever possible.

Role of the intervention leads

- To change the soft words poster every day or so.
- To remind other members of the team what the soft words are.
- To draw attention to the message of the day poster in the staff office.
- To distribute the postcards to all the staff at times they see fit.

Local examples

- Print a range of postcards or cards with different soft words messages and hints. Place the cards in staff pigeonholes on a regular basis as a prompt or reminder.
- Create some ward-specific soft words for common times when you might use soft words (such as the introduction of smoke free environment).
- Place the soft words in a folder with plastic sleeves so people can flip through and read the examples.
- Place the posters up high so they stand out.

Talk down

Background

When people become agitated, angry and upset and it seems they might become aggressive or be at risk of harming themselves, it is often possible to talk to them to help them calm down. That process is called de-escalation, defusing or diffusion. Most staff get some instruction in these skills as part of prevention and management of aggression courses; however the coverage is not always thorough or at an advanced level. This is because no one has previously pulled all the different techniques together or assembled them into a meaningful picture.

Research on aggression shows that the people on wards who are most vulnerable to being assaulted by patients are unqualified nurses and student nurses. Therefore, they most need to learn talk down skills so they can avert aggressive incidents. However, it is likely that all staff would benefit from reading the de-escalation poster and adopting those techniques that are not yet part of their interpersonal skill repertoire.

This intervention provides an organised catalogue of talk down tips, showing how they fit together into a three-stage process of de-escalation. The process has been derived from research and professional literature from many countries on the topic of violence prevention; it is brought together in this format for the first time.

Description

This intervention includes the development of tools as well as identification of a talk down lead.

A *talk down methods* poster summarising basic to advanced de-escalation techniques will be placed in areas frequented by staff. This is available on the Safewards website.

The ward will decide who amongst the staff is the best at de-escalation and this person will be nominated as the talk down lead. The talk down lead will explain the poster to all staff, give them additional supporting information and encourage them to ask questions.

Role of the intervention leads

For this intervention, the lead should be a person on the ward who is considered to be good at de-escalation.

The poster is a guide only. All de-escalation situations vary. The poster summarises how the process would work ideally. The reality is usually more unpredictable; nevertheless, these principles can be applied to most situations to some degree.

- **Prepare yourself:** Take a good look at the poster. The three boxes across the middle describe the process of de-escalation in the order in which they occur.

  Delimiting is about establishing safety and getting started. **Clarifying** is about eliciting and hearing what the patient has to say and establishing the nature of the problem. **Resolving** is about addressing the issue you have just clarified, via appeal, negotiation, compromise or giving choices.

  The top and bottom boxes describe the staff qualities and responses that have to be displayed throughout the process for a resolution to be achieved: self-control, respect and empathy. Read the contents of all the boxes and think about the times you have used these techniques or followed this advice.

- **Explain the poster to others:** Take 10 minutes with each staff member (one by one) to explain the poster, providing examples from your own experience. Answer questions from all staff and give them each a copy of *Staying open, friendly and positive*.
- **Identify and acknowledge when these skills are used:** Point out to other members of the team when they use these skills effectively. Mention talk down in handovers or other team meetings. Express respect for their use of talk down; acknowledge the growing skill of the team. Some wards use the poster when debriefing following an incident – recognising the skills that were used and those that were not, and so helping staff identify ways in which de-escalation could be improved.

Local examples

- Place the poster in a common area (such as outside the nursing station) where de-escalation is used, where staff and patients can see the poster and to aid the process of talk down.
- Use the talk down intervention for de-escalation and management of aggression training.
- As the talk down poster, even at A1 size, can be difficult to read, one service creatively expanded on the poster by placing key points from each of the boxes outside the poster in speech bubbles, drawing people's attention to the key points.
- Take the poster to an incident debrief and use it to reflect on the incident and the process of de-escalation.
- Place the talk down model on a lanyard.

Recommended reading

Lavelle, M, Stewart, D, James, K, Richardson, M, Renwick, L, Brennan, G & Bowers, L 2016, 'Predictors of effective de-escalation in acute inpatient psychiatric settings'*. Journal of Clinical Nursing*, 25, pp. 2180-2188

Reassurance

Background

Patients can react with fear or anger after events or episodes, such as violence, absconding, the admission of acutely unwell patients, arguments and containment measures (like physical restraint or coerced intramuscular medication). Night may be particularly frightening for patients, especially if they are unfamiliar with the environment and are sharing a sleeping area with people they do not know. The symptoms of their illness may also make them vulnerable to stress. Patients may wake to the sound of shouting in the middle of the night and lie awake fearfully imagining what might be going on.

Patients are also affected by the stereotypes and stigma attached to mental illness as portrayed in the media. They too may perceive their fellow patients as strange or frightening. The commonplace media picture of madness as uncontrolled violence also permeates the patients' views of each other. They may be sure that they pose no threat to others, but they are by no means sure about the threat posed by other patients. Occasionally these fears are overlaid with paranoid ideation or delusions, producing a powerful motivation to abscond or be defensively aggressive. More frequently, just plain fear of assault is motivation enough. Any confrontation between patients or between patients and staff, even if only verbal, can raise the anxiety of patients to unbearable levels.

These reactions partly explain why one event triggers another, why if there is one significant incident on the ward, a second is more likely to occur.

This intervention seeks to reduce the risk of 'contagion' between patients by allaying the anxieties that occur in circumstances where patients may react with fear or anger following certain events.

Description

Following the occurrence of a potentially anxiety-provoking incident on the ward, every patient should be engaged in a conversation (either alone or in small groups) to ask their understanding of what happened and what affect it has had on them and to explain what happened. If not all patients witnessed the incident or heard of it, then only those who have could be engaged.

Following an incident, staff should make sure they are more visible and out on the ward with patients, moving about, covering the whole ward, being noticeably watchful, not in an anxious way (which would make things worse) but in a warm, caring, non-negative way. The goal of staff presence, explanation and support is to ensure everyone feels safe and secure.

Potentially anxiety-provoking incidents

- Shouting, property damage or physical aggression – may provoke fear, anxiety, stress and agitation in patients that can lead to defensive aggression, absconding, withdrawal and disengagement from ward therapeutic activities.
- Self-harm – may provoke copycat acts, particularly in suggestible patients, can also be distressing and anger-provoking that someone can do this or provoke fear of one’s own internal impulses.
- Absconding – may suggest the idea to those who had not thought about it or affect the security practices on the ward.
- Intoxication – provokes fear and anxiety about the unpredictable way the intoxicated person may behave towards others on the ward and may raise concerns about other patients on the ward who may have consumed the same substance and therefore behave aggressively or unpredictably.
- Use or show of force, physical restraint, coerced intramuscular medication, seclusion or transfer of a patient to high dependency/extra care/intensive care – undermines the patient’s confidence in staff, makes them feel vulnerable, which is all too easily misinterpreted as bullying, abusive, excessive use of force, therefore provoking anger and/or fear.

Explanations to patients

- Explanations given to patients do not have to be indiscreet or break confidentiality. The explanations you give can draw upon psychological explanations for patients' behaviour and use generalities. For example:

  > ‘Sometimes when people get ill they may be unaware of what is going on and they can become very frightened and confused. That means they can be aggressive and we may need to intervene to keep everyone safe. We have a plan on the ward to reduce the use of these practices and we try to avoid them as much as possible by acting before these things come to a head. When we have to act we try to do so caringly, respectfully and without bearing any grudges afterwards. They are not punishment. They are about keeping everyone safe’.

Role of the intervention leads

- To take the lead in making sure reassurance happens following any incident when they are on duty.
- When an incident is mentioned at the handover, to ask if ‘reassurance' took place.

Local examples

- Embed the practice of reassurance and document it in policy and procedure.
- Use reassurance in the mutual help meeting.
- Create a reassurance folder that contains prompts for how to engage patients in this intervention and how to maintain confidentiality.

Discharge messages

Background

Many people are admitted in a state of depression and hopelessness, which may be masked by anger and resentment toward the staff and the hospital. There are many ways to help patients regain hope and get a sense of purpose about their admission, for example by expressing care and concern for them, attending to them and listening to their concerns.

The discharge messages intervention provides a further method to imbue hope and convey authoritative messages about the purpose and benefit of an admission. Patient engagement and messages from patients describing a positive aspect of their own experience directed to other patients on the ward is fundamental to this intervention.

Description

On the day of their discharge (or in the days leading up to discharge), each patient is asked to write a card for display on a discharge message board on the ward (whatever form that maybe be, see some examples below). The card should say what they liked about the ward, the staff and what occurred on the ward during their stay. It should also include their most positive and helpful piece of advice for new patients. The card should be selected from those available and include a picture of the patient's preference. The member of staff can write the message for the patient if that is easier, but the patient should be asked to write their first name at the end of their message, so those remaining on the ward will know who it is from. The card should be placed on the discharge message noticeboard. New patients can be shown these messages for reassurance and to increase feelings of hope.

Role of the intervention leads

- Check the discharge messages tree or noticeboard, keep it tidy and remind staff to get the cards when a patient's discharge is forthcoming.
- Make sure patients about to be discharged are identified at handover and that someone is allocated to assist them in writing a discharge message.
- Remove old cards.
- Ensure others are aware of privacy and that people are not coerced into writing messages.

Local examples

- Apply themes to the message wall/noticeboard/tree. For example, one ward during the Easter period had an Easter Bunny painted on the wall holding baskets and the messages were in the form of Easter eggs placed in the baskets.
- Use space creatively. One ward placed their discharge message tree over a section of a wall that had glass at the top of the wall with painted leaves.
- Display rotating discharge messages on a monitor visible on the unit.
- Stay true to the principle of discharge messages by placing any messages that may not be true to the intervention (such as messages of thanks) in another location or folder (such as a scrapbook).

Positive words

Background

Handovers are generally the only time the team gets together to discuss each patient on the ward. Handovers have a critical organisational function, ensuring that the oncoming shift knows what has been happening, what the main risks are, what new patients have been admitted, and what has to happen in the following shift.

However, in the report of what has happened during the shift, the focus is often on exceptional behaviour; that is, behaviour that is difficult to manage or presents risks to the patient or others. Focusing on exceptional behaviour may promote a negative perception of patients, rather than a balanced view of strengths and ways of working with a person.

This intervention aims to balance the natural tendency to focus on exceptional behaviour by saying something positive about each patient at handover and, when difficult behaviour is described, by offering potential psychological explanations. This intervention aims to promote the positive appreciation of patients and reduce the likelihood of further conflict. It calls on the clinician's skill in knowing the patient and how people present in times of stress.

Description

During handover, staff should say something positive about what each patient has been doing during the shift or draw attention to a positive quality. If this is not possible (although this is unlikely), they should say something positive about the way the person was supported (positive appreciation).

In addition, if any difficult or disruptive behaviour is reported, a possible psychological understanding of the patient's behaviour must be offered. The document, *Understanding unsafe and risky patient behaviour*, will help in constructing psychological explanations.

Areas for positive comments

Suggestions from the UK Research Team: past achievements of the patient, before admission or illness; positive personality trait; achievements; engagement in activities; improvements; expression of an interest in something; demonstration of coping or effort, for example struggle or courage in adversity; a contribution to another patient or to patients as a whole; something the patient has enjoyed; interesting things about the patient; visits and phone calls that went well; how the patient reminds you of somebody well known and highly regarded.

Suggestions from the UK service user group:

Positively reframe, positively connote, find a positive aspect to some behaviour, such as demonstrated patience with others, endurance and courage, seemed to be coping better, had a really good conversation with me, managed to say something to me, was getting on well with other patients.

Say something positive regarding a patient's personal history, for example they used to be a teacher, artist, diplomat; engaged with and attended occupational therapy activity.

Positively reframe something that might be seen negatively, for example. was assertive rather than disruptive; supporting their defences, for example, casting 'negative' responses in a psychologically understanding way; had a bath; enjoyed activities; interacted well with named nurse/doctor; ate all their food; took meds calmly; stated meds were helping them feel better; enjoyed a walk; slept well; less disruptive; interacted more today; said they were feeling positive and looking forward to discharge; enjoyed leave/what they did; has not paced up and down; has smiled and made eye to eye contact; took themselves to the sensory room; returned to the ward on time after home leave; looks brighter.

Role of the intervention leads

In every handover, remind or require the person doing the handover to use positive words by asking

- 'What is the positive message about this patient?'
- ‘Why do we think the patient might have behaved in that way?'

Give every member of staff a copy of the document, *Understanding unsafe and risky patient behaviours*, which they can use to interpret patient behaviour.

Local examples

- Incorporate the principles of positive words into patient-centred handovers (also known as bedside handovers).
- Use a visual prompt to remind staff during handover to use positive words.
- Ensure staff have access to the document *Understanding unsafe and risky patient behaviours.* Make sure there are copies available in the place where handover occurs.
- Audit handovers to ensure that positive words is occurring.
- Display positive words on a wall as a prompt for handovers.

Appendices

Appendix 1: Safewards project plan

Project purpose

Outline the purpose of the project.

Project objectives

The objectives of the project are to:

Project scope

Define the project scope

Project requirements

The project will require:

- establishment of a Safewards steering committee
- development of a project plan describing the implementation of Safewards
- ensuring staff have a clear understanding of the Safewards model, including the rationale underpinning the model and how the 10 interventions relate to the model
- ensuring that understanding of the Safewards model is shared between the multidisciplinary team
- participating in project evaluation.

Project outputs

At the end of the 12-month project period, the following outputs will be delivered:

1. Safewards model implemented in the designated wards
2. A project evaluation is completed describing the effectiveness of the model in the wards that implemented Safewards

Anticipated outcomes

The anticipated outcomes of the project include, but are not limited to:

- reduction in use of restrictive interventions, including seclusion and restraint
- increased awareness and management of factors giving rise to conflict within wards
- embedding sustained cultural and practice change within wards in relation to restrictive interventions
- enhanced consumer experiences of care and safer environment for all through reduced frequency of conflict and containment events for consumers.

Implementation planning

The following detail is provided to guide implementation planning for wards implementing Safewards.

Key dates

Task	Date
Steering committee established	
Ward/service implementation finalised	
Evaluation commences	
Staff training completed	
Safewards implementation commences	

Leadership and governance arrangements

Please briefly describe (up to 200 words) the governance arrangements for the introduction of Safewards onto your ward.

Consumer and carer participation

Please briefly describe (up to 200 words) how consumers and carers have been/will be involved in the implementation of Safewards on your ward.

Evaluation

Evaluation	*Please briefly describe how the success of the Safewards implementation on your ward will be determined*		
Deliverables/milestones		**Date**	**Status**
Please list the milestones of your Safewards implementation			*To be done/Doing/Done*
Overall progress			**Ahead/As planned/Behind**
Risks and contingencies	*Please briefly list up to four key risks associated with implementing Safewards on your ward and the contingency measures in place to address them*		

Performance measures

Performance Measures
1. *Please list the performance measures to be used by your service to monitor the success of your Safewards implementation*
2.
3.
4.
5.
6.

Signatures

Executive Sponsor

Project Lead

Print name

Print name

Appendix 2: Safewards preparation checklist

Tasks	Y/N
Preparation	
1. Goals have been set identifying what successful implementation of Safewards looks like at the service	
2. Internal criteria for measuring success have been established	
3. Appropriate staff have been selected to deliver the training	
4. Training delivery has been scheduled for all staff	
5. All staff have been communicated with about the implementation	
6. All staff have attended the Safewards training	
7. All ward staff have viewed the training videos and read the instructions for each of the interventions (available on the Safewards website)	
8. All staff are aware of who the lead is for each of the interventions	
9. A plan has been prepared to guide the practical implementation of each intervention	
10. Responsibility for each implementation action has been allocated to somebody	
11. A process is in place to provide ongoing review of the Safewards implementation	
Clear mutual expectations	
1. Leaflets for patients about the meeting have been prepared	
2. Suitable days and times for this meeting have been identified	
3. A log book for the meeting has been obtained	
4. A champion for this intervention has been appointed	
Bad news mitigation	
1. A system for highlighting/considering potential/actual bad news at shift handovers has been identified	
2. A champion for this intervention has been appointed	
Soft words	
1. A frame for holding the soft words A4 sheets has been acquired and hung in the ward office	
2. A4 soft words sheets have been printed on different coloured paper and are stored on the ward	
3. The three reminder postcards have been printed and copies are with the champion to distribute at selected times	
4. A champion for this intervention has been appointed	
Reassurance	
1. A system for highlighting events that require reassurance to the patient community at shift handovers has been identified	
2. A champion for this intervention has been appointed	
Positive words	
1. A system for reminding staff to do this at shift handovers has been identified	
2. Copies of *Understanding unsafe and risky patient behaviours* have been printed for all staff	
3. A champion for this intervention has been appointed?	
Calm down methods	
1. A list of potential contents for the box has been drawn up	
2. The contents of the box have been agreed with a senior occupational therapist	

3. The contents of the box have been agreed with the appropriate lead for infection control	
4. The contents of the box have been agreed with the ward staff who will use it	
5. A crate or other similar box for the equipment has been obtained	
6. The contents of the box have been obtained	
7. A log book has been prepared so that equipment can be checked in and out	
8. A location on the ward where the box will be kept has been agreed	
9. A champion for this intervention has been appointed	
Discharge messages	
1. The ward has decided on a tree, poster or other equivalent and where it will be placed	
2. The tree, poster or equivalent has been obtained	
3. The postcard-sized notes/leaves for patients to write on have been obtained	
4. A champion for this intervention has been appointed	
Know each other	
1. A good quality, robust and attractive folder has been obtained	
2. A system for laminating A4 sheets is available to the ward	
3. Sheets for collecting information about staff and patients are available	
4. A champion for this intervention has been appointed	
Talk down	
1. Copies of *Staying open, friendly and positive* have been printed for all staff	
2. The talk down poster has been printed (A1 size) and laminated	
3. A place for hanging the talk down poster has been identified	
4. A champion for this intervention has been appointed	
Mutual help meeting	
1. Leaflets for patients about the meeting have been printed out	
2. Suitable days and times for this meeting have been identified	
3. A log book for the meeting has been obtained	
4. A champion for this intervention has been appointed	

Appendix 3: Intervention summary, resources and roles

Intervention	Description	Implementation resources/requirements	Role of the intervention leads
Clear mutual expectations	Clear mutual expectations relate to staff and patients – just as staff have expectations of patients, patients have expectations of staff. Clarifying relationships allows staff to be consistent and patients to better understand their obligations and those of staff. Communication between the two will be eased and clarity in the social environment will assist patients to think more clearly and experience less irritation and frustration.	• Full intervention description • Posters to display the agreed upon clear mutual expectations • Mutual expectation meetings • Scenarios	To ensure that mutual expectations meetings occur, communicate the results to the ward, approve proof copies of the poster, and ensure they are hung at appropriate places on the ward. If you are the admitting nurse, to convey the clear mutual expectations poster to the patient and explain the contents. If you are on duty when a patient is admitted, remind the admitting nurse to do the same. If you are in handover and a newly admitted patient is described, ask whether the clear mutual expectations poster has been shown and explained.
Soft words	This intervention provides some ways to avoid confrontation and work collaboratively with patients. It is communicated to the team through: - a 'message of the day' poster displaying soft words tips, to be placed in the ward office and regularly changed - postcards with hints and messages in an interesting format as a booster.	• Full intervention description • Posters • Postcards • Scenarios	To change the soft words poster every day or so. To remind other team members what the soft words are. To draw attention to the message of the day poster in the nurses office. To distribute the postcards to all the staff at times they see fit.
Talk down	This intervention recommends two approaches: Place a poster summarising basic to advanced de-escalation techniques in an area frequented by staff, preferably the nursing office. Identify which staff member is the best at de-escalation and ask this person to be the talk down lead. They will spend 10–15 minutes with each member of the team, explaining the poster and giving examples from their own experience.	• Full intervention description • Talk down poster • Scenarios • *Staying open, friendly and positive document*	For this intervention, the lead should be a person on the ward who is considered to be good at this. The poster is a guide only. All de-escalation situations vary. The poster summarises how the process would work ideally. Explain the poster to all other members of staff (one by one). Answer questions about the poster contents. Include examples from their own experience. Give a copy of *Staying open friendly and positive* to each person. Identify and acknowledge when these skills are used. Point out to other members of the team when these skills are used effectively. Mention it in handovers or other team meetings.

Intervention	Description	Implementation resources/requirements	Role of the intervention leads
Positive words	At handover, staff should say something positive about what each patient has been doing or draw attention to a positive quality. If this is not possible, say something positive about the way staff supported the patient (appreciation). If any difficult or disruptive behaviour is reported, offer a possible psychological understanding of the patient's behaviour (see *Understanding unsafe and risky patient behaviour*)	• Full intervention description • Positive words record sheet • *Understanding unsafe and risky patients behaviour* document • Scenarios	In every handover, remind or require the person doing the handover to use positive words by asking: 'what is the positive message about this patient?' or 'why do we think the patient might have behaved in that way?' Give every member of staff on the ward a copy of the document, *Understanding unsafe and risky patient behaviours*. Use this document to interpret patient behaviour on the ward.
Bad news mitigation	Bad news from home can precipitate conflict for patients. Severe examples would be a death in the family or the termination of a relationship with an intimate partner. Also things like the loss of tenancy, a burglary, illness in the family and childcare issues, can all represent blows to patients. The resulting stress can be acted out on the ward in increased irritability, aggression, violent incidents and absconding. This initiative helps us notice these moments rapidly and act fast to mobilise psychological and social support for the patient, before the distress turns into a conflict.	• Full intervention description • Scenarios	To make sure these two questions are considered by the team at handover: Has any patient received bad news over the past shift and, if they have, how can we support them? Is anyone likely to receive bad news during the coming shift and, if so, how are we going to manage that?
Know each other	Each member of staff will provide non-controversial information about themselves that they are happy to be communicated to patients. This could include their qualifications, years of experience working in mental health, previous jobs, hobbies and interests. The information will be placed on a single laminated sheet in a 'know each other folder', which is made available to patients. If the patient is willing, staff are to ask patients and carers upon admission a list of questions that can help produce a profile of who the patient is as a person, key background information, such as their likes, dislikes, favourite things, quotes, beliefs etc. Staff can refer to this profile to get to know their patients better and for conversation triggers. This can be accompanied by a graphic or picture of the patient's choice. The patient information will be added to the same know each other folder.	• Full intervention description • Staff form • Patient form • Folder cover • Scenarios	To lead in collecting the background information, printing out the sheets and laminating them. To draw the attention of patients to the information. To make sure the know each other folder stays out on the ward. To replace any sheets that get lost or mislaid.

Intervention	Description	Implementation resources/requirements	Role of the intervention leads
Mutual help meeting	A voluntary meeting of all patients and the staff on duty, to be held preferably first thing in the morning, and preferably every day (no less than three times a week). The meeting is about how everyone can help each other during the day. It follows a structured agenda and once all the points are covered, the meeting can be closed. The meeting does not have to be chaired by a staff member. The four agenda points can be incorporated into other ward meetings for all patients and staff if required.	• Full intervention description • Patient leaflet for mutual help meeting • Poster advertising mutual help meeting • Scenarios	To hold the first meeting and explain to patients what it is about. To attend these meetings as frequently as possible.
Calm down methods	Calm down methods is a box of equipment that can be used by patients to help lower their levels of arousal and agitation. When a patient is noticed to be tense or agitated or showing other known indicators that they might become angry and aggressive, these calm down methods should be offered before considering PRN medication. All patients should be appropriately supervised when using calm down items, and some activities can be done by the patient and staff member. The box of items should be kept in a locked office, cupboard or staff room. After use, blankets and pillows can be washed on the ward or taken away for cleaning by others as organised locally.	• Full intervention description • Box of calm down equipment for your ward	To suggest calm down methods are used on appropriate occasions. To ask at handover if they have used calm down methods when people describe agitation or used PRN medication. To check the calm down box regularly and make sure items have been returned, contents are in good order, clean and working Secure replacements for missing, depleted or broken items.
Reassurance	Following a potentially anxiety-provoking incident on the ward, patients aware of the incident should be engaged in a conversation, either alone or in small groups, to ask their understanding of what happened, what effect it has had on them and to explain what has happened. Staff should make increased efforts in the short term to be more visible on the ward, being noticeably watchful in a warm, caring, non-negative way. The goal of staff presence, explanation and support is to ensure everyone feels safe and secure.	• Full intervention description • Scenarios	To take the lead in making sure this happens following any incident when they are on duty. When an incident is mentioned at the handover, to ask if 'reassurance' took place.

Intervention	Description	Implementation resources/requirements	Role of the intervention leads
Discharge messages	On the day of discharge, ask each patient to write a card for display on a public noticeboard on the ward. Select a card from those available and include a picture of the patient's preference. The card should say what they liked about the ward, the staff and what went on in the ward during their stay. It should include their most positive and helpful piece of advice for new patients. The member of staff can write the message for the patient if that is easier, but the patient should be asked to write their first name at the end of their message. The card should be hung on the discharge messages tree or noticeboard. New patients can be shown these messages for reassurance and to increase feelings of hope.	• Full intervention description • Scenarios	To check the discharge messages tree or noticeboard, keep it tidy, and remind staff to get the cards when a patient's discharge is forthcoming. To make sure imminently discharged patients are identified at handover and that someone is allocated to help them write a discharge message.

Appendix 4: Safewards implementation planning

Implementation item	Task	Responsible	Completion date
E.g. Ensure leadership team buy-in	*Present Safewards at executive forums/meetings*	*Project sponsor*	
E.g. Staff communications to build awareness	*Present Safewards at handover* *Develop and issue email bulletins*	*Project lead*	

This template is based on the Te Pou *Planning for Implementation template*

Appendix 5: Safewards intervention implementation plans

The following templates can be used when planning implementation of each of the interventions.

Safewards implementation plan

Know each other

Opportunities

How will this intervention support a reduction in conflict and containment?

e.g. Support a sense of community and camaraderie

Challenges

What kind of systemic or cultural barriers might get in the way of implementation?
e.g. Unwillingness to share information

Key tasks

In sequence, what steps need to be taken to achieve implementation?

Activity	When	Who
e.g. Orient staff to the intervention		*Unit managers/consumer educator*

Resources

What materials are available or required for education and implementation?

What already exists?	What needs to be sourced?
e.g. Know each other folder	

Activities and communications

What activities or communications can be used to support implementation and education?

e.g. Get know each other samples from the project team/service leadership.

Notes

Safewards implementation plan

Clear mutual expectations

Opportunities

How will this intervention support a reduction in conflict and containment?

e.g. Create a dialogue around the necessary and unnecessary limitations that can cause conflict.

Challenges

What kind of systemic or cultural barriers might get in the way of implementation?
e.g. The inadvertent creation of a list of rules that applies mostly to consumers.

Key tasks

In sequence, what steps need to be taken to achieve implementation?

Activity	When	Who
e.g. Decide on a process for consultation between consumers and carers		*Unit managers/consumer educator*

Resources

What materials are available or required for education and implementation?

What already exists?	What needs to be sourced?
e.g. Poster template	

Activities and communications

What activities or communications can be used to support implementation and education?

e.g. Planning focus/reflection groups with the multidisciplinary team…

Notes

Safewards implementation plan

Mutual help meeting

Opportunities

How will this intervention support a reduction in conflict and containment?

Challenges

What kind of systemic or cultural barriers might get in the way of implementation?

Key tasks

In sequence, what steps need to be taken to achieve implementation?

Activity	When	Who

Resources

What materials are available or required for education and implementation?

What already exists?	What needs to be sourced?
e.g. Mutual help meeting agenda template	

Activities and communications

What activities or communications can be used to support implementation and education?

Notes

Safewards implementation plan

Calm down methods

Opportunities

How will this intervention support a reduction in conflict and containment?

Challenges

What kind of systemic or cultural barriers might get in the way of implementation?

Key tasks

In sequence, what steps need to be taken to achieve implementation?

Activity	When	Who

Resources

What materials are available or required for education and implementation?

What already exists?	What needs to be sourced?

Activities and communications

What activities or communications can be used to support implementation and education?

Notes

Safewards implementation plan

Bad news mitigation

Opportunities

How will this intervention support a reduction in conflict and containment?

Challenges

What kind of systemic or cultural barriers might get in the way of implementation?

Key tasks

In sequence, what steps need to be taken to achieve implementation?

Activity	When	Who

Resources

What materials are available or required for education and implementation?

What already exists?	What needs to be sourced?

Activities and communications

What activities or communications can be used to support implementation and education?

Notes

Safewards implementation plan

Soft words

Opportunities

How will this intervention support a reduction in conflict and containment?

Challenges

What kind of systemic or cultural barriers might get in the way of implementation?

Key tasks

In sequence, what steps need to be taken to achieve implementation?

Activity	When	Who

Resources

What materials are available or required for education and implementation?

What already exists?	What needs to be sourced?

Activities and communications

What activities or communications can be used to support implementation and education?

Notes

Safewards implementation plan

Talk down

Opportunities

How will this intervention support a reduction in conflict and containment?

Challenges

What kind of systemic or cultural barriers might get in the way of implementation?

Key tasks

In sequence, what steps need to be taken to achieve implementation?

Activity	When	Who

Resources

What materials are available or required for education and implementation?

What already exists?	What needs to be sourced?
e.g. talk down poster	

Activities and communications

What activities or communications can be used to support implementation and education?

Notes

Safewards implementation plan

Reassurance

Opportunities

How will this intervention support a reduction in conflict and containment?

Challenges

What kind of systemic or cultural barriers might get in the way of implementation?

Key tasks

In sequence, what steps need to be taken to achieve implementation?

Activity	When	Who

Resources

What materials are available or required for education and implementation?

What already exists?	What needs to be sourced?

Activities and communications

What activities or communications can be used to support implementation and education?

Notes

Safewards implementation plan

Discharge messages

Opportunities

How will this intervention support a reduction in conflict and containment?

Challenges

What kind of systemic or cultural barriers might get in the way of implementation?

Key tasks

In sequence, what steps need to be taken to achieve implementation?

Activity	When	Who

Resources

What materials are available or required for education and implementation?

What already exists?	What needs to be sourced?

Activities and communications

What activities or communications can be used to support implementation and education?

Notes

Safewards implementation plan

Positive words

Opportunities

How will this intervention support a reduction in conflict and containment?

e.g. Demonstrating unconditional positive regard.

Challenges

What kind of systemic or cultural barriers might get in the way of implementation?
e.g. Some clinicians may resist a change in language and devalue the intervention.

Key asks

In sequence, what steps need to be taken to achieve implementation?

Activity	When	Who
e.g. Hold an education/reflective practice session with all staff focusing on language		*Project lead/consumer consultant*

Resources

What materials are available or required for education and implementation?

What already exists?	What needs to be sourced?

Activities and communications

What activities or communications can be used to support implementation and education?

Notes

Appendix 6: Activity templates

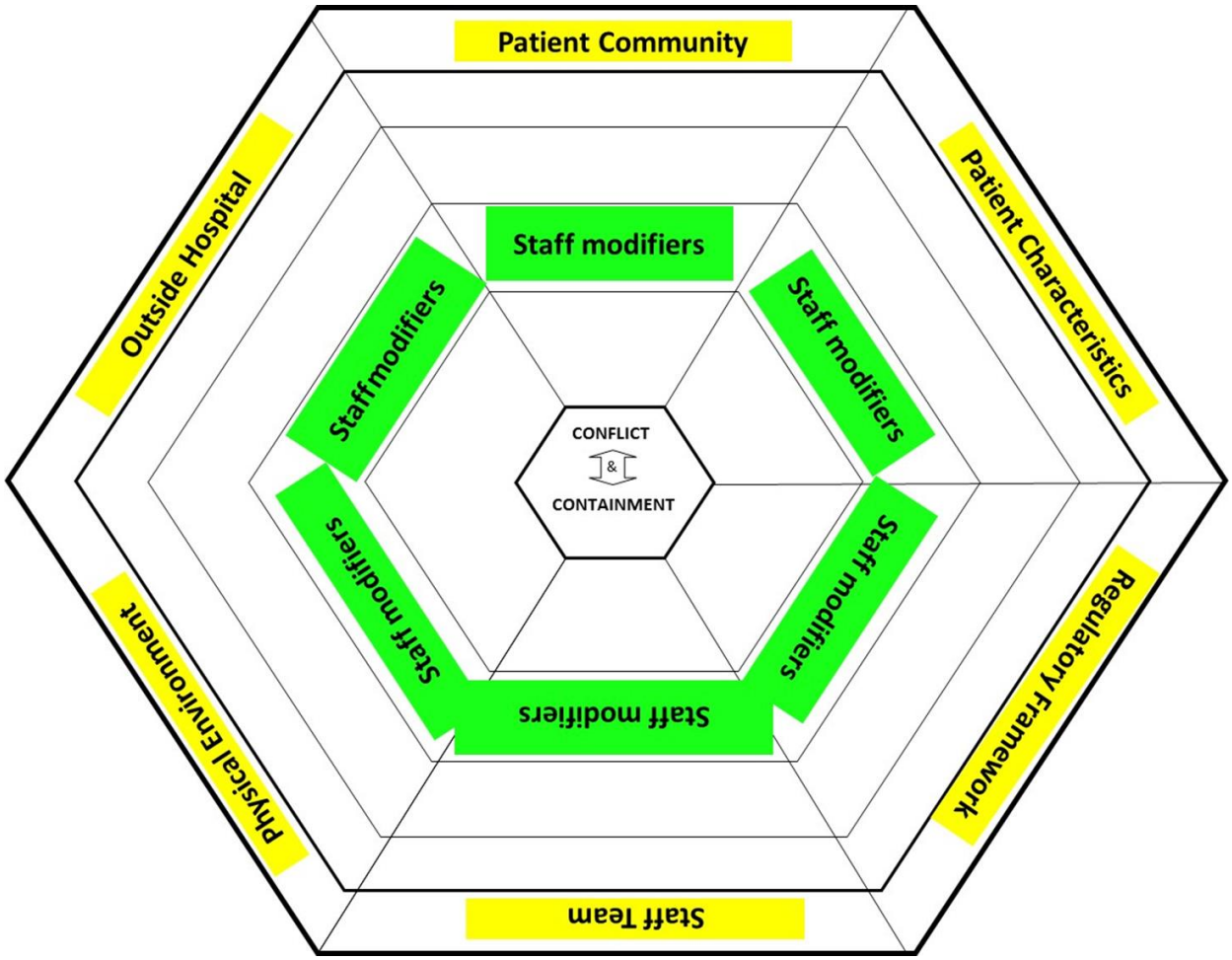
The following templates can be used when running activities described in the Safewards Victoria PowerPoint resource.

Walking in someone else's shoes

List of jobs:

- Stay-at-home parent
- Lawyer
- School teacher
- Pharmacist
- Dentist
- Police officer
- Website designer
- Engineer
- Accountant
- Priest
- State MP
- Car sales
- Real estate agent
- Bank teller
- Financial planner
- Insurance broker
- University lecturer
- Journalist
- Working in retail
- Waiter/waitress
- Union leader
- On DSP due to symptoms of schizophrenia
- On DSP due to symptoms of bi-polar
- Bank manager
- Bar owner
- Student
- Security guard
- Cleaner
- Firefighter
- Pilot
- Farmer
- Childcare worker
- Flight attendant
- Hairdresser
- Plumber
- Postal worker
- Builder
- Mechanic
- Truck driver
- Taxi driver
- Call centre worker
- Actor/Actress
- Musician
- Part-time car cleaner (and in rehab for long-term mental illness)

Identifying flashpoints and modifiers



Antecedents of violence and aggression

Patient – patient interaction	Staff-patient interaction	Patient conflict behaviours	External/ personal	Structural Issues	Patient behavioural cues	Patient emotional/mood cues
	Medication- related containment			Environmental issues		
	Any other containment			Regime issues		
	Any other staff-patient interaction					

Consequences of violence and aggression

Physical injury	Containment/staff response	Patient transferred/discharged	Victim psychological outcome	Victim behavioural outcome

Appendix 7: Handover prompts

Three of the interventions (positive words, bad news mitigation, reassurance) require specific action at the nursing handovers, three per day.

This prompt sheet is a resource for the leads of those three interventions and for the nursing staff leading handover. These questions reflect the items for these interventions in the Safewards fidelity checklist.

Bad news mitigation

1. Are any patients likely to receive bad news during the next shift?
    a. Discuss potential strategies that may help to mitigate the bad news for this patient

    Yes ☐ No ☐

2. Did anyone receive bad news during the previous shift?
    a. Discuss the strategies that were used and how these worked

    Yes ☐ No ☐

Reassurance

1. Did any of the following incidents occur? Tick all that apply

Physical aggression	
Attempted suicide	
Seclusion	
Restraint	
Coerced IM medication	
Transfer to HDU or elsewhere	

2. If any of the above occurred, did Reassurance take place?

    Yes ☐ No ☐

Positive words

1. Were positive words used when discussing each patient?

    Yes ☐ No ☐

References

Bowers, L 2009, ‘Association between staff factors and levels of conflict and containment on acute psychiatric wards in England’. *Psychiatric Services,* 60, pp. 231–239.

Bowers, L 2012. ‘Safewards: a new model of conflict and containment on psychiatric wards’, *Journal of Psychiatric and Mental Health Nursing,* 21(6), pp. 499–508.

Bowers, L, Alexander, J, Bilgin, H, Botha, M, Dack, C, James, K, Jarrett, M, Jeffery. D, Nijman, H, Owiti, JA, Papadopoulos, C, Ross, J, Wright, S & Stewart, D 2014, ‘Safewards: the empirical basis of the model and critical appraisal’, *Journal of Psychiatric and Mental Health Nursing,* 21, pp. 354–364.

Bowers, L, Douzenis, A, Galeazzi, G, Forghieri, M, Tsopelas, C, Simpson, A & Allan, T 2005, ‘Disruptive and dangerous behaviour by patients on acute psychiatric wards in three European centres’, *Social Psychiatry and Psychiatric Epidemiology,* 40, pp. 822–828.

Bowers, L, James, K, Quirk, A, Simpson, A, SUGAR, Stewart, D & Hodsoll, J 2015, ‘Reducing conflict and containment rates on acute psychiatric wards: the Safewards cluster randomised controlled trial’, *International Journal of Nursing Studies,* 52, pp. 1412–1422.