# Safewards

## Virtual Workshop

LISA SPONG

# Presentation 1: Safewards introduction overview

**Origins of Safewards:**

- **What is Safewards**
- **Research conducted**
- **Strengths and weaknesses of the research**
- **How the model was developed**

**The six domains that influence conflict**

**Definition of Conflict and Containment**

- **Restraint**

# Origins of the Safewards Model

- Nursing model
- Developed by Len Bowers, UK
  - Trialled and evaluated in Victoria
- Research-based
- Focus on conflict and containment (restrictive interventions)

**Evidence (Bowers)**

- Cross topic literature review
- Model development
- Cluster randomised controlled trial of model
  - 31 units, adequate power, significant results
  - Conflict 14.6% decrease
  - Containment 23.6% decrease

# Six domains that influence or trigger conflict

## Originating Domains

- Patient Community
- Patient characteristics
- Regulatory framework
- Staff team
- Physical environment
- Outside hospital


**Definition:**
Social and psychological situations arising out of features of the originating domains, signaling and preceding  imminent conflict

# Conflict and Containment

## Safewards centres around reducing **conflict** and **containment**

**Conflict** means anything that could lead to harm for the patient, other patients or staff:

- Physical aggression
- Verbal aggression
- Self harm/ suicide
- Substance misuse
- Property damage
- Leaving against medical advice(Absconding)
- Medication refusal

*These occurrences may lead to restrictive interventions*

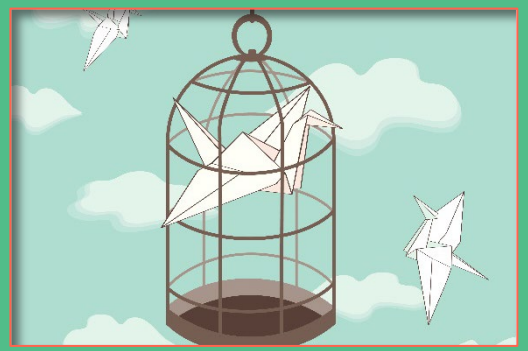
**Containment** means what staff do to prevent conflict events or minimise harmful outcomes, and may include:

- Special observation
- Use of security
- Physical restraint
- Chemical restraint
- Seclusion
- Mechanical restraint
- Environmental restraint

# Conflict and Containment

## Conflict

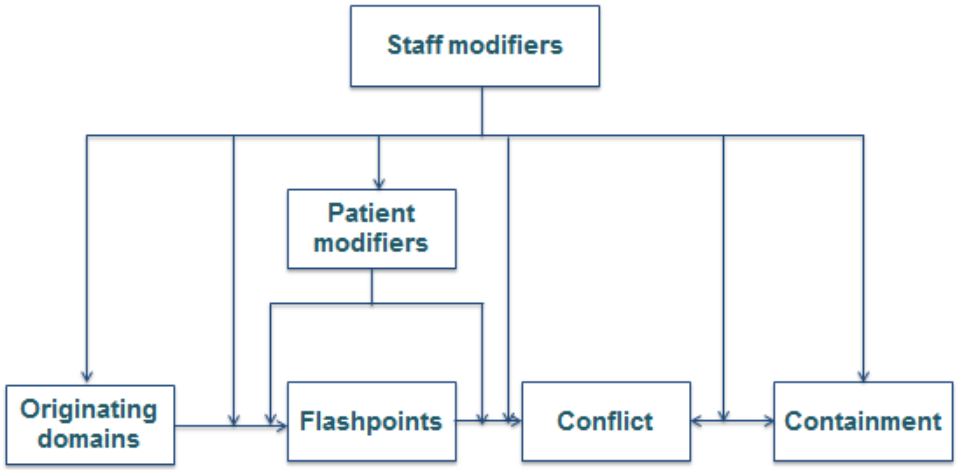
## Containment



# 15min break – morning tea

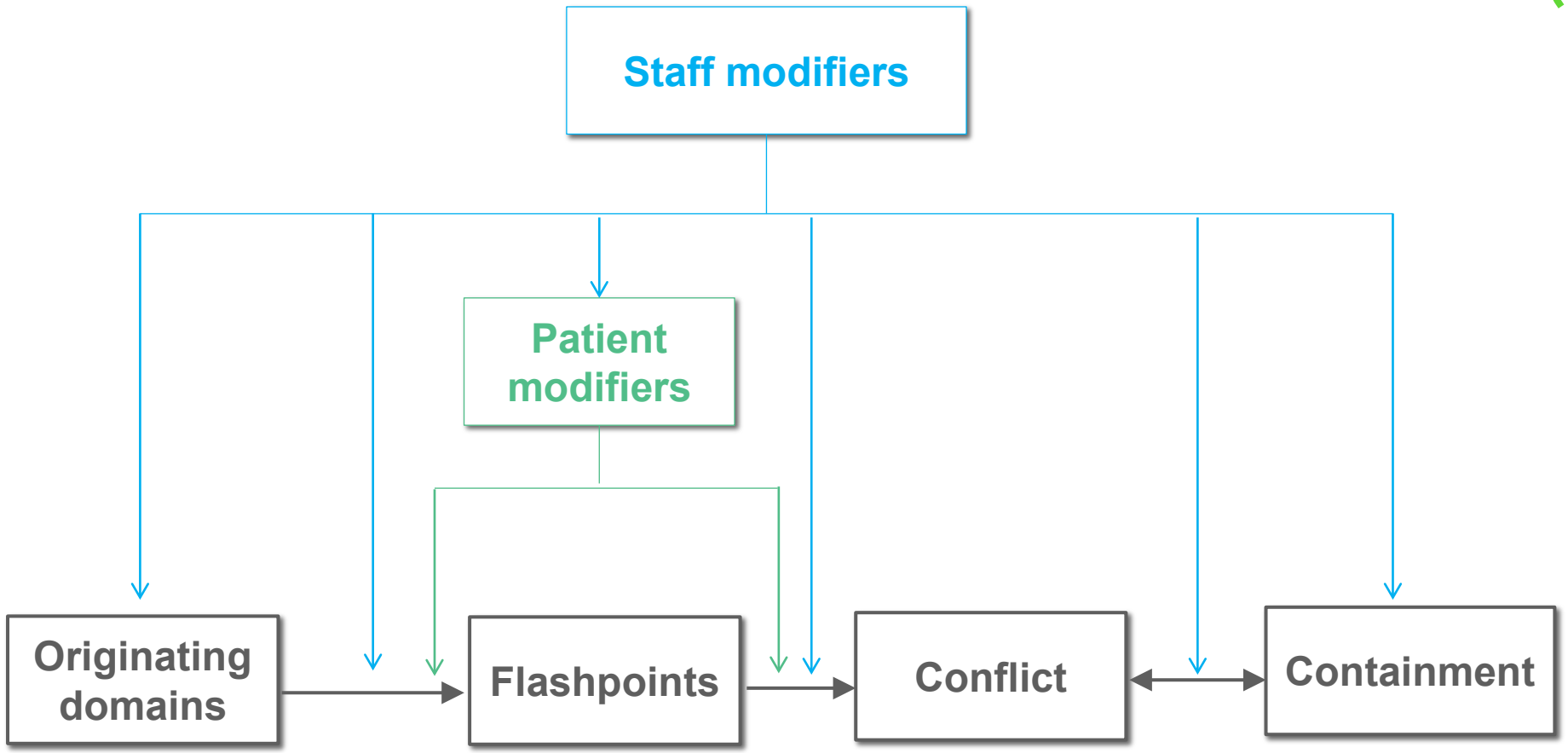
# Activity One

## Simple model




## Technical model

# Simple model



# Originating Domains

Factors that can influence the frequency of conflict and containment:

- social and physical locations of units
- separation from a person’s normal residence
- provision of 24/7 mental health care
- mixed voluntary and legal coercion

# Staff Modifiers

**Definition**

Characteristics of staff or teams or the way staff act in working with patients or the environment

**Potential**

The way staff initiate or respond to interactions can influence the frequency of conflict and containment

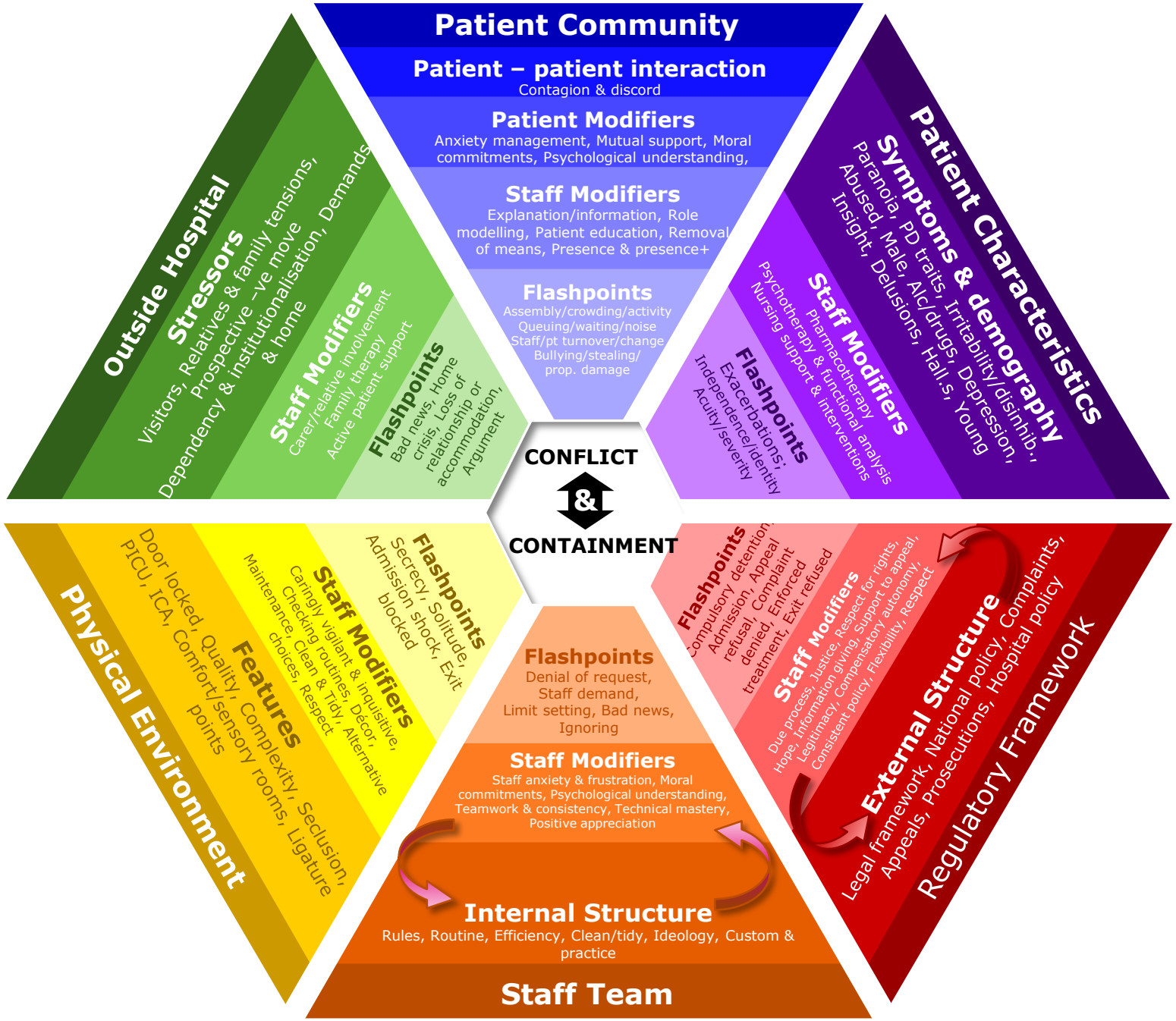
# Patient Modifiers

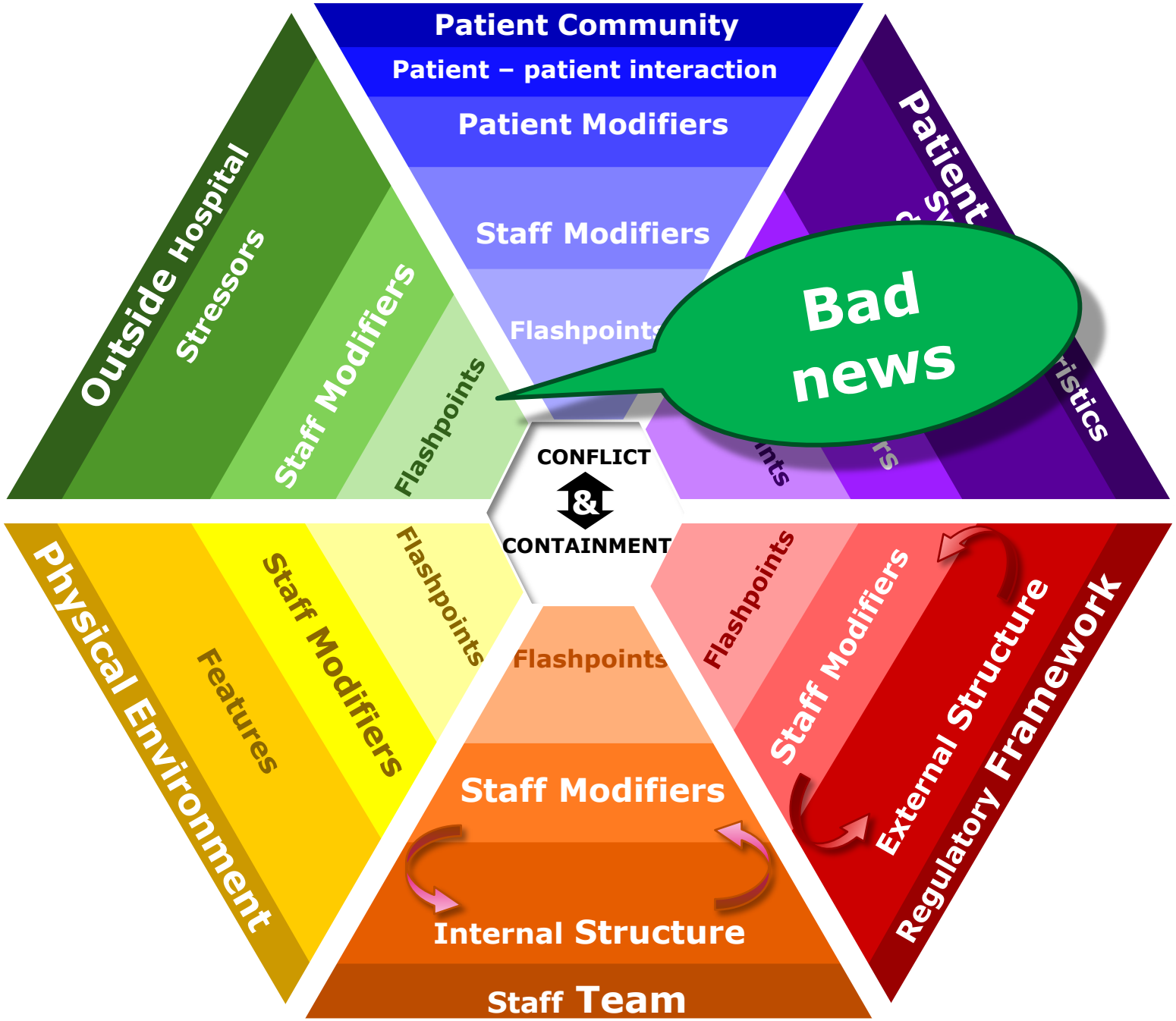
**Definition**

How patients respond and behave towards each other can influence the frequency of conflict and containment.

Patients are susceptible to staff influence.

# Facilitated group activity


Patient Community
Patient – patient interaction
Contagion & discord
Patient Modifiers
Anxiety management, Mutual support, Moral commitments, Psychological understanding,
Staff Modifiers
Explanation/information, Role modelling, Patient education, Removal of means, Presence & presence+
Flashpoints
Assembly/crowding/activity
Queuing/waiting/noise
Staff/pt turnover/change
Bullying/stealing/ prop. damage
Outside Hospital
Stressors
Visitors, Relatives & family tensions, Prospective –ve move
Dependency & institutionalisation, Demands & home
Staff Modifiers
Carer/relative involvement
Family therapy
Active patient support
Flashpoints
Bad news, Home crisis, Loss or relationship or accommodation, Argument
Patient Characteristics
Symptoms & demography
Paranoia, PD traits, Irritability/disinhib., Abused, Male, Alc/drugs, Depression, Insight, Delusions, Hall.s, Young
Staff Modifiers
Psychotherapy & functional analysis
Pharmacotherapy
Nursing support & interventions
Flashpoints
Exacerbations, Independence/identity
Acuity/severity
CONFLICT
&
CONTAINMENT
Physical Environment
Features
Door locked, Quality, Complexity, Seclusion, PICU, ICA, Comfort/sensory rooms, Ligature points
Staff Modifiers
Caringly vigilant & inquisitive, Checking routines, Décor, Maintenance, Clean & Tidy, Alternative choices, Respect
Flashpoints
Secrecy, Solitude, Admission shock, Exit blocked
Flashpoints
Denial of request, Staff demand, Limit setting, Bad news, Ignoring
Staff Modifiers
Staff anxiety & frustration, Moral commitments, Psychological understanding, Teamwork & consistency, Technical mastery, Positive appreciation
Internal Structure
Rules, Routine, Efficiency, Clean/tidy, Ideology, Custom & practice
Staff Team
Flashpoints
Compulsory detention, Admission, Appeal refusal, Complaint denied, Enforced treatment, Exit refused
Staff Modifiers
Due process, Justice, Respect for rights, Hope, Information giving, Support to appeal, Legitimacy, Compensatory autonomy, Consistent policy, Flexibility, Respect
External Structure
Legal framework, National policy, Complaints, Appeals, Prosecutions, Hospital policy
Regulatory Framework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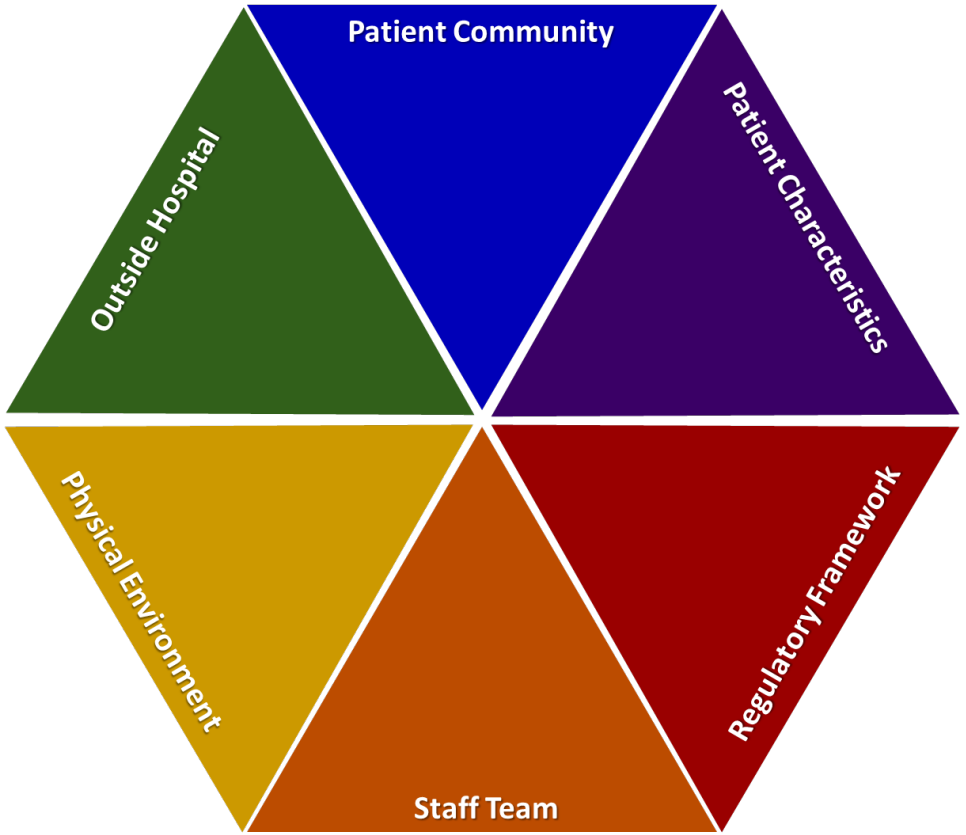
# Overview of originating domains



# Staff Team domain

## Internal structure

Rules, routines, efficiency, clean/tidy, ideology, custom, practice

## Staff modifiers

Staff anxiety and frustration, moral commitments (honesty), psychological understanding, teamwork and consistency, technical mastery, positive appreciation, education/training, clinical supervision, model skills, challenge each other, review care provided, focus on flashpoints, finding better ways to manage them (reduce number of rules, pre-empting needs) and set limits

## Flashpoints

Denial of request, staff demand, limit setting, bad news, ignoring

# Regulatory Framework domain

## External structure

Legal framework, national policy, complaints, appeals, prosecutions and hospital policy

## Staff modifiers

*With the exception of hospital policy, these modifiers are not under staff control (RRI); however, the way they are carried out can be*. This includes:

Procedural justice, respect for rights, hope, information giving, supported decision making, support to appeal, legitimacy, compensatory autonomy, consistent policy, flexibility, effective complaints process, policy targeted at RRI, choices (such as more activities, meals, snacks), intervene to address hopelessness and self-stigmatisation.

## Flashpoints

Compulsory detention, admission, appeal refusal, complaint denied, enforced treatment and exit refusal

# Physical Environment domain

Better quality environment versus complexity (observation/supervision)

## Features

Door locked, quality of environment, speedy repairs, complexity, seclusion rooms available, PICU, ICA, comfort/sensory rooms, ligature points

## Staff modifiers

Vigilant and inquisitive, checking routines, décor, maintenance, clean and tidy, alternative choices, respect

## Flashpoints

Secrecy, solitude, admission shock, exit blocked

# Outside Hospital domain

**Stressors**

Visitors, relatives and family tensions and relationships, missing out, dependency and institutionalisation (absconding), demands and home

**Staff modifiers**

Carer/relative involvement, family therapy, active patient support, awareness, important factors from outside that can influence behaviour on the unit (financial circumstances, support to resolve issues with family and friends, accommodation-checked on/leave to visit)

**Flashpoints**

Bad news, home crisis, loss of relationship or accommodation, argument

# Patient Community domain

**Patient-patient interaction**

Ripple effect of conflict (impact of conflict elsewhere on the unit, living with others, meal times and medication times)

**Patient modifiers**

Anxiety management, mutual support, moral commitments, psychological understanding, technical mastery

**Staff modifiers**

Explanation/information, role modelling, patient education, removal of means, presence and presence+ (getting in early), conflict resolution, pre-emptive reassurance, managing level and fluctuation of activity on the unit

**Flashpoints**

Assembly, crowding, activity queuing, waiting, noise, staff/patient turnover or change, bullying, stealing and property damage

# Patient Characteristics domain

## Symptoms and demography

1. Symptoms: paranoia-defensive, aggression, specific delusions, depression-suicide attempts/irritability, use of substances, irritability or disinhibition
2. Personality traits: features of ASPD, instrumental aggression
3. Demographic: particularly being younger and male

## Staff modifiers

Pharmacotherapy, psychotherapy and functional analysis; nursing support and intervention; enhance choices, freedom and control over circumstances; develop mutually respectful partnership; therapeutic community; authoritarianism-counterproductive; CBT; social skills training; trauma-informed practice responses; choices over how to respond. Only a few people account for the majority of aggressive incidents, therefore:

1. change responses after the first event to avoid subsequent events
2. target therapeutic interventions

## Flashpoints

Exacerbations, independence, identity, acuity, severity

# Presentation 2: Safewards Interventions 1-5

**Know Each Other**

**Soft Words**

**Calming Methods**

**Bad News Mitigation**

**Talk Through**

# Safewards Interventions

*The Safewards interventions are a set of prevention and intervention strategies developed to correspond to diverse flashpoints identified in the model*

# Know Each Other

## Know each other

You do not need to answer every question on this form, but please tell us something about yourself.

This will be typed up, laminated and put in a folder which will be kept in the communal areas of the ward – to help people get to know each other.

**Name:**

**Likes:**

**Dislikes:**

**Hobbies / interests:**

**Previous / current occupations:**

**Favourite films:**

**Favourite TV programmes:**

**Favourite books:**

**Favourite music:**

**Favourite quote:**

**Beliefs:**

**Anything else you'd like to say about yourself?**

# Background

- Good therapeutic relationships between staff and patients are the foundation of effective care
- If patients and staff have information about each other they can find common areas of interest
- Sharing areas of interest makes engagement easier for both patients and staff, especially in tense situations
- It’s helpful to have topics for conversation

# AIMS

- Build stronger relationships between patients, and between patients and staff
- Assist social interaction
- Nurture a sense of common humanity while maintaining safety

**...making conflict less likely**

# Soft Words


Seek to **understand** behaviour and what **need** it **expresses.**
Offer to meet that need in a different way.
Explain in **detail** and with **good reasons** why you cannot give patients **exactly** what they want.

# Background and aims

## Background

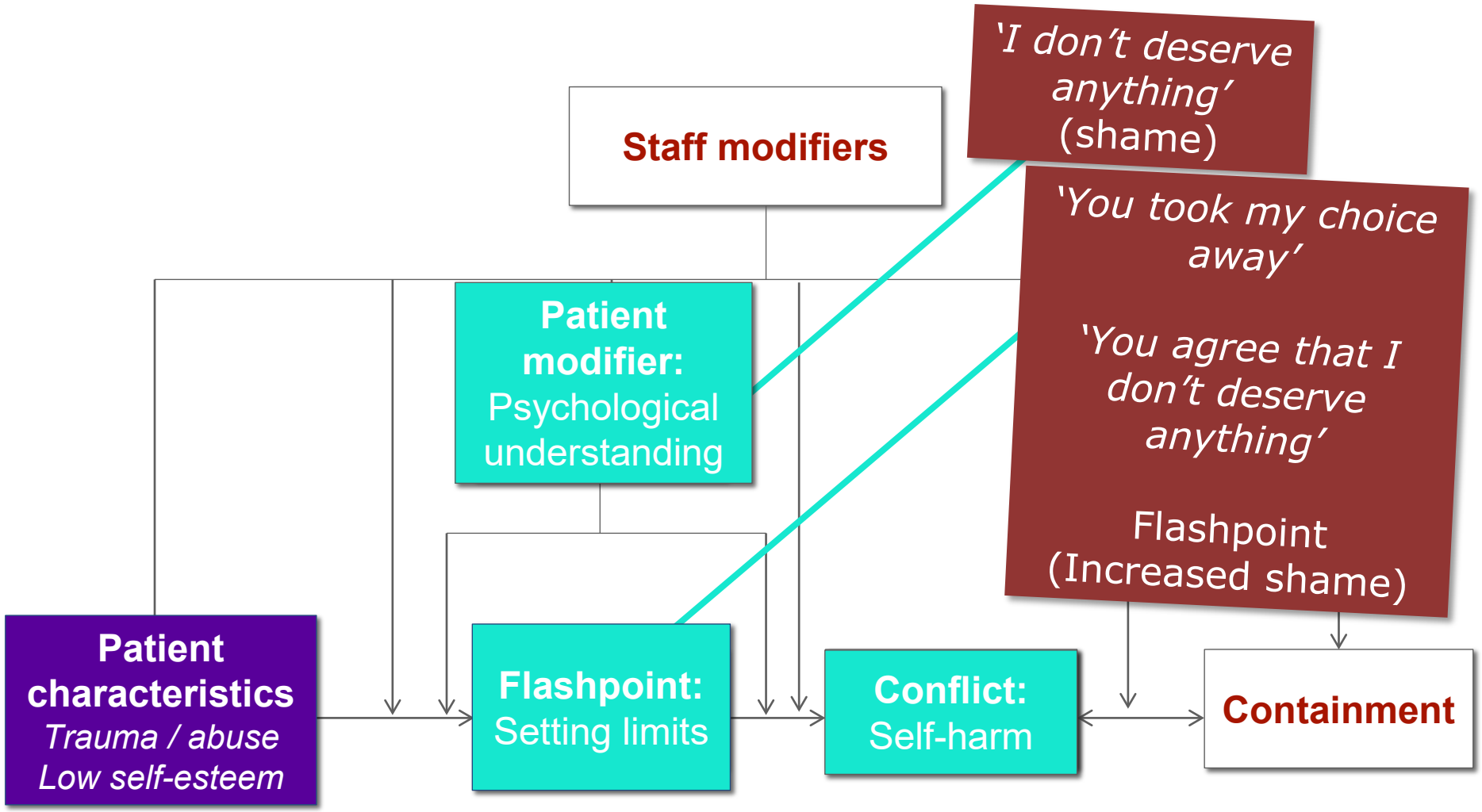
A primary flashpoint leading to violent incidents is limit setting. Whenever staff ask patients to do something (or stop them from doing something), this can give rise to understandable frustration.

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

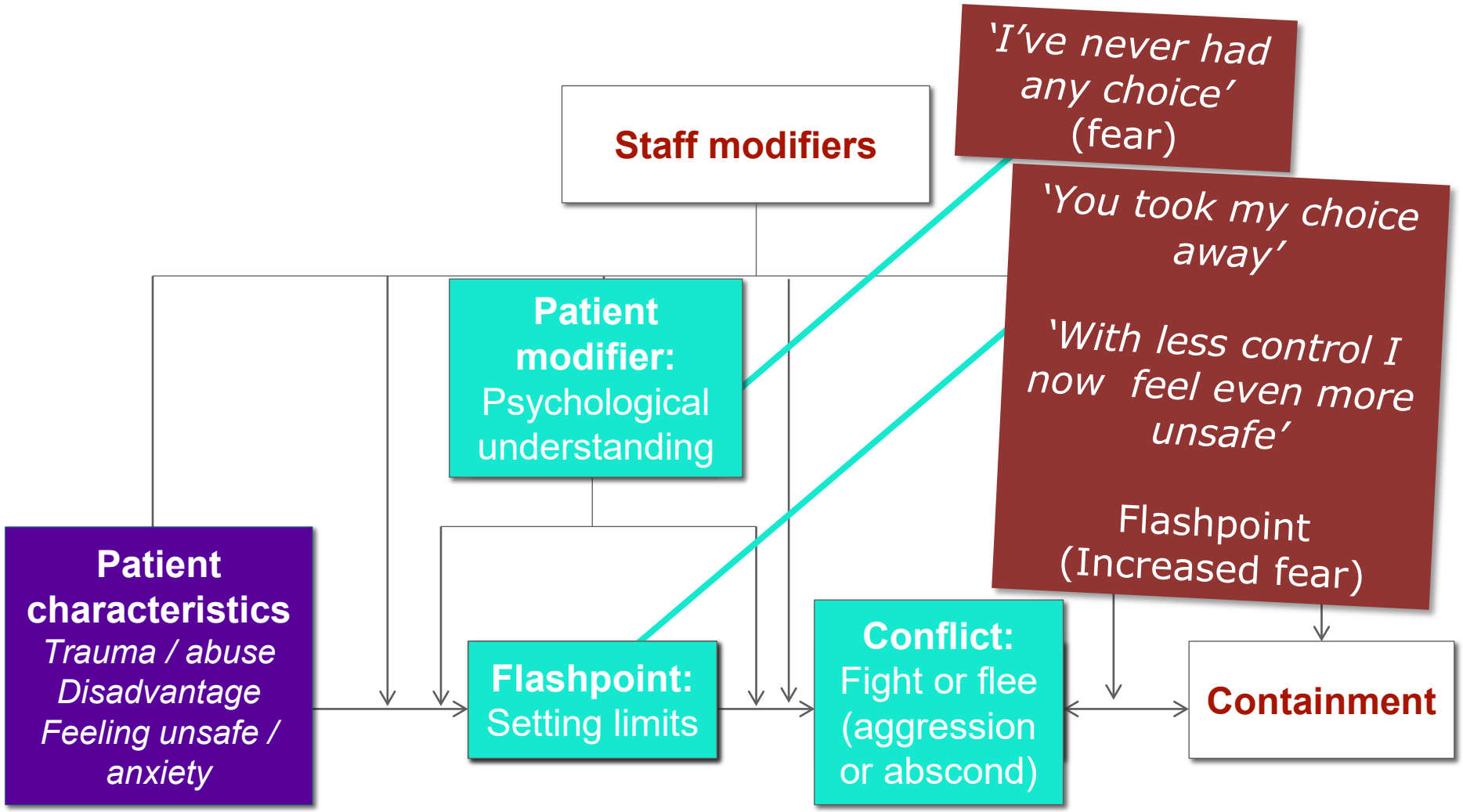
## Aims

- Expand staff skills and choices in relation to limit setting and flashpoint situations
- Increase the options available on the unit

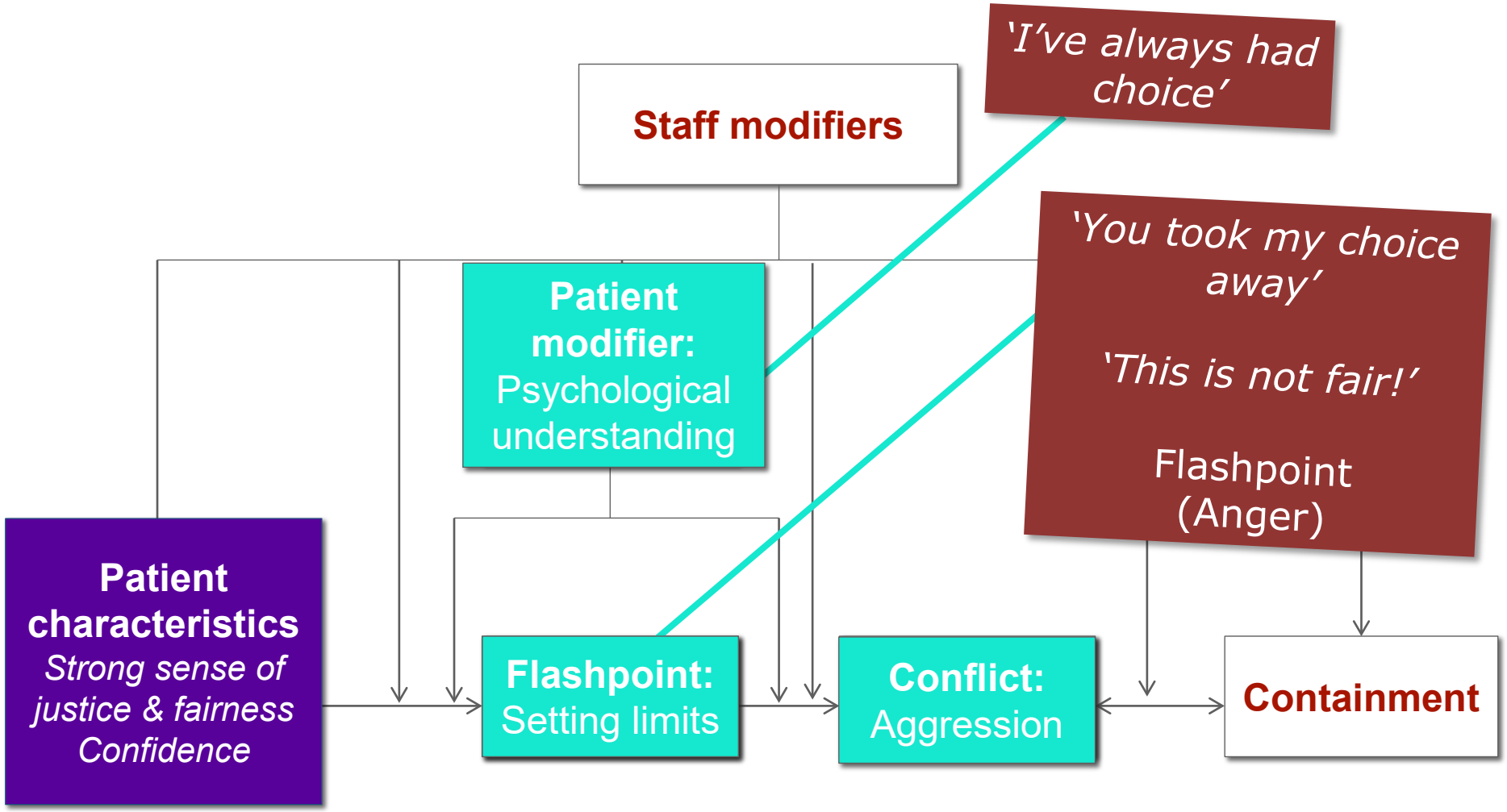
# Soft Words: Why it matters (example 1)



# Soft Words: Why it matters (example 2)



# Soft Words: Why it matters (example 3)



# Calming Methods

# Background and Aims

**Background**

Pro re nata (PRN) medication can been used as an effective strategy to assist people to feel calm, but perhaps we reach for it too easily and too quickly. Where possible and practical, it's always best to use the patient's own strengths and coping mechanisms – or support people to develop new strengths and skills – to enable people to self-regulate.

**Aims**

- Early de-escalation
- Divert and prevent
- Increase people's sense of empowerment and self-control (these processes contribute to recovery)

# Bad News Mitigation

# Background

People can be affected greatly by unwelcome news, and may want to leave the unit to seek familiar support or escape the cause of the news.

If people have no choice to leave the unit when distressed, they may express feelings in an unsafe way.

**The resulting distress can cause increased irritability, aggression, violent incidents and abscond.**

# Aims

Receiving bad news can be common during an inpatient admission. This intervention is about providing support during the delivery of news or afterwards, to mitigate the risk of flashpoints.

## Key messages:

- Bad news can create confusion and hinder understanding.
- Be respectful of a person’s views.
- Being aware of occasions when people might get upsetting news.
- Identify a proactive way to reach out to people before there is a reactive need to.

# Talk Through

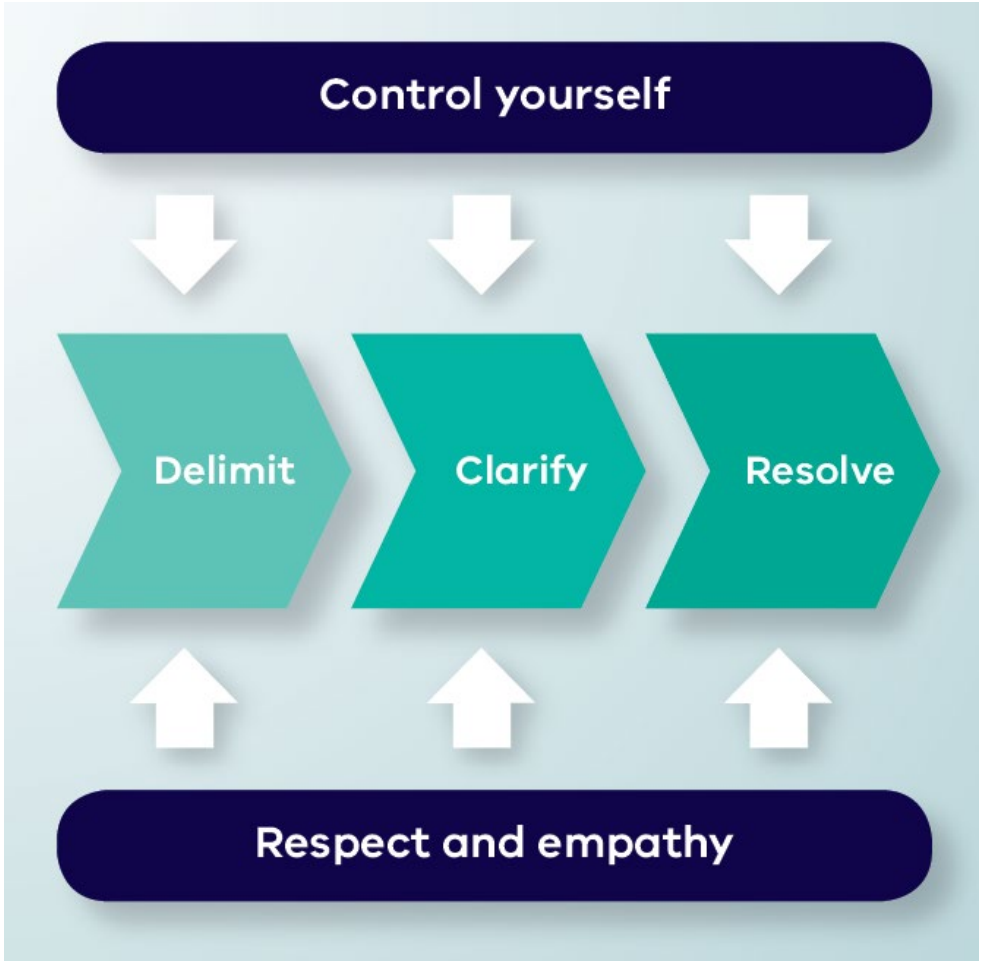
# Background

- When people become agitated, fearful, angry, ashamed, depressed or suicidal, it should be possible to lessen people's distress by talking to them
- Most of us have had instruction in de-escalation in aggression management training but this may be limited
- Safewards pulls together 'Talk Through' techniques into a meaningful picture

# Aims

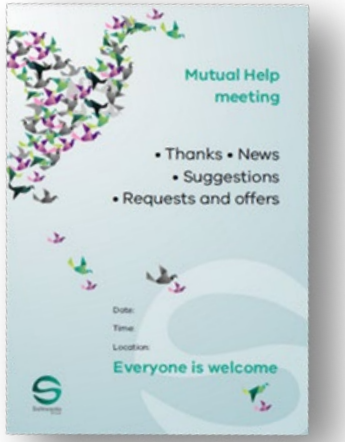
- Build patient's emotional self-management skills, self-monitoring, self-awareness and psychological understanding
- Using crisis as an opportunity for therapeutic learning for everyone
- Improve team cohesion, skill sharing, mutual support
- Expand staff skill set
- Avoid conflict and containment - or minimise the impact in the event of conflict and/or containment

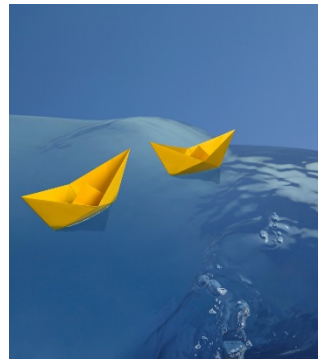
# Talk Through process

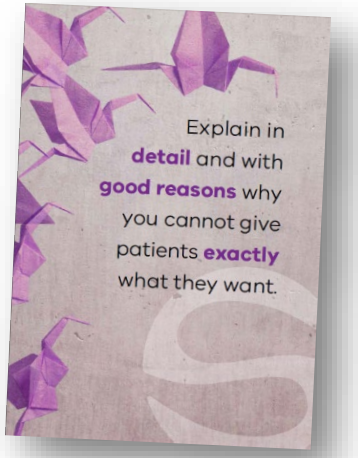


# Lunch break

# Activity Two





# Presentation 3: Safewards Interventions 6-10

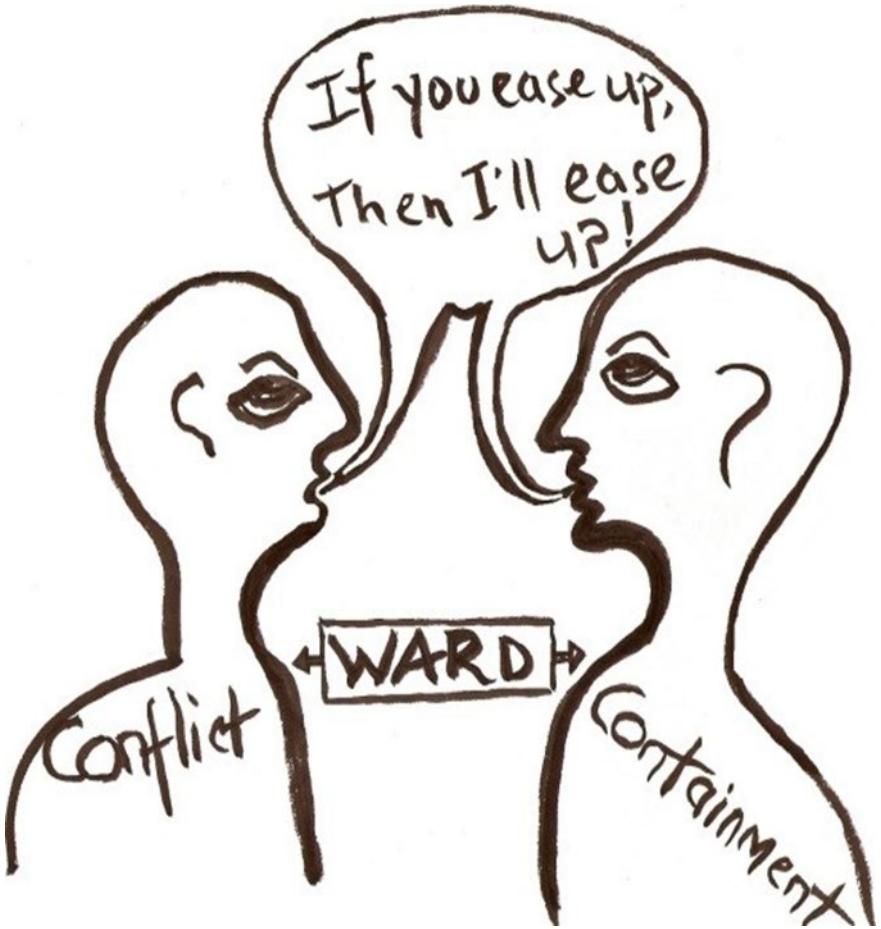
**Reassurance**

**Positive Words**

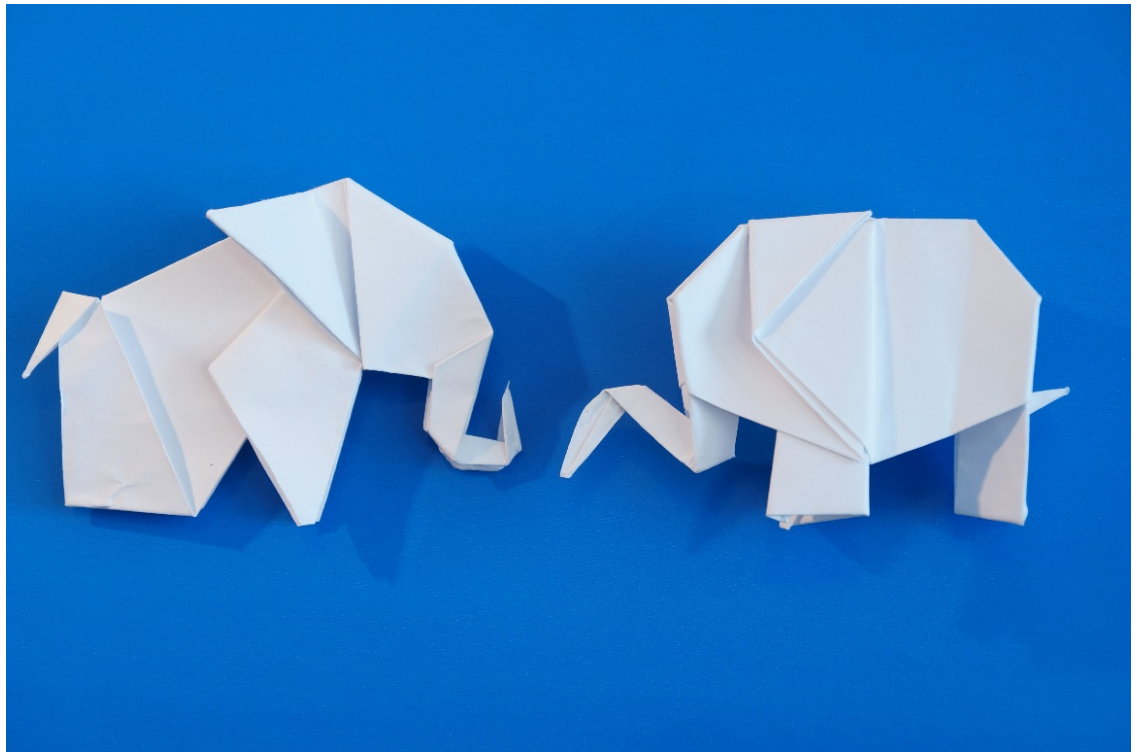
**Discharge Messages**

**Mutual Help Meeting**

**Clear Mutual Expectations**



# Reassurance



# Reassurance Background

Psychiatric units can be strange and scary places.

Every confrontation has the potential to be a flashpoint for another patient, creating a kind of ripple effect.

Unlike staff, patients are not always free to leave the unit or get away to a safe place.


Patients don't have to be directly involved in a confrontation for it to have a distressing emotional impact. Staff can help alleviate fear and other types of distressing emotions.

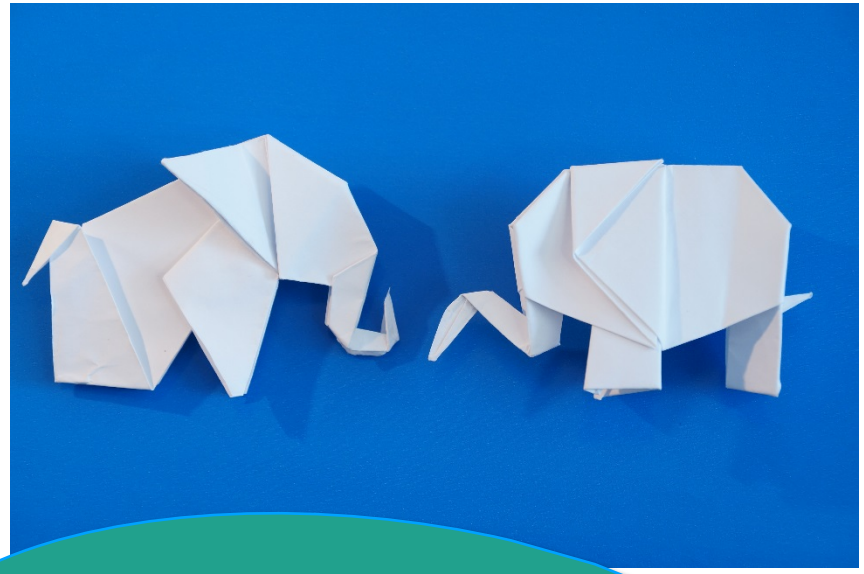
# Reassurance Aims

To proactively reassure **every** patient after **every** confrontation,  incident or conflict on the unit

To reduce the potential ripple effect of conflict on the unit

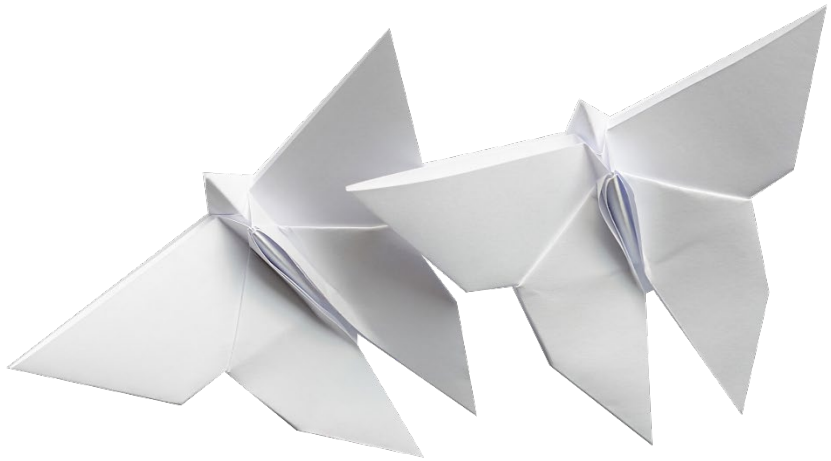
To prevent or reduce the impact of flashpoints

To ensure patients feel safe and supported



Reassurance for patients is a bit like debriefing for staff

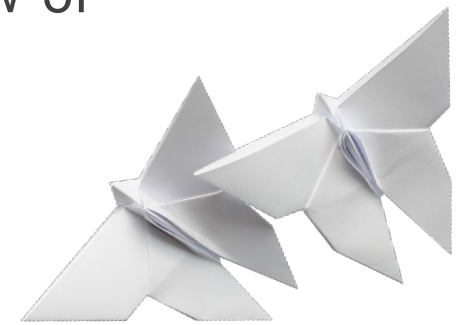
# Positive Words



# Background and aims

## Background

At handover the focus is often on describing challenging behaviour or risks to the patient or others. This may promote a negative perception of patients, rather than a balanced view of strengths and ways of working with a person.



## Aims

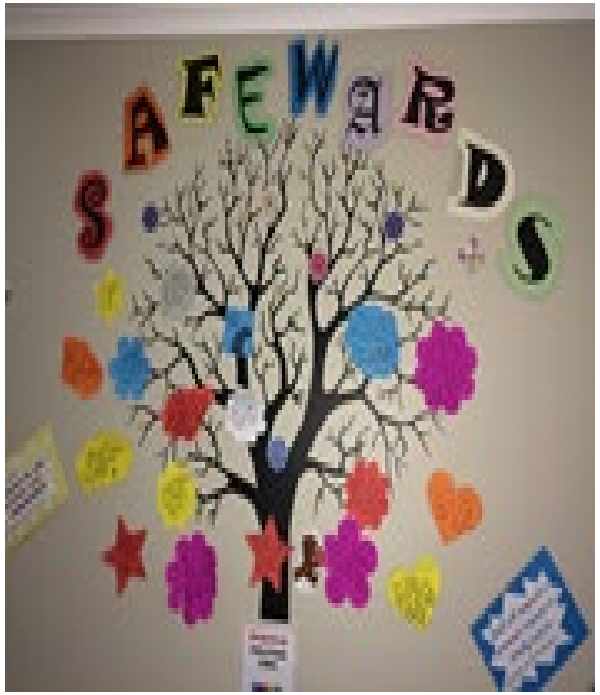
- Know peoples' strengths as well as their challenges
- Give the staff something positive and practical to work with
- Set an optimistic start to every shift
- Try to redress the power differential (remember the person is not in the room!)

# Discharge Messages

# Background

Discharge messages provides a way of helping people connect with hope by:

- Demonstrating care and concern
- Attending to what people feel and are concerned about
- Creating an avenue for patients to inspire and support each other (even anonymously)
- Providing hopeful messages from other patients (rather than from staff)




**Patient engagement is fundamental to this intervention**

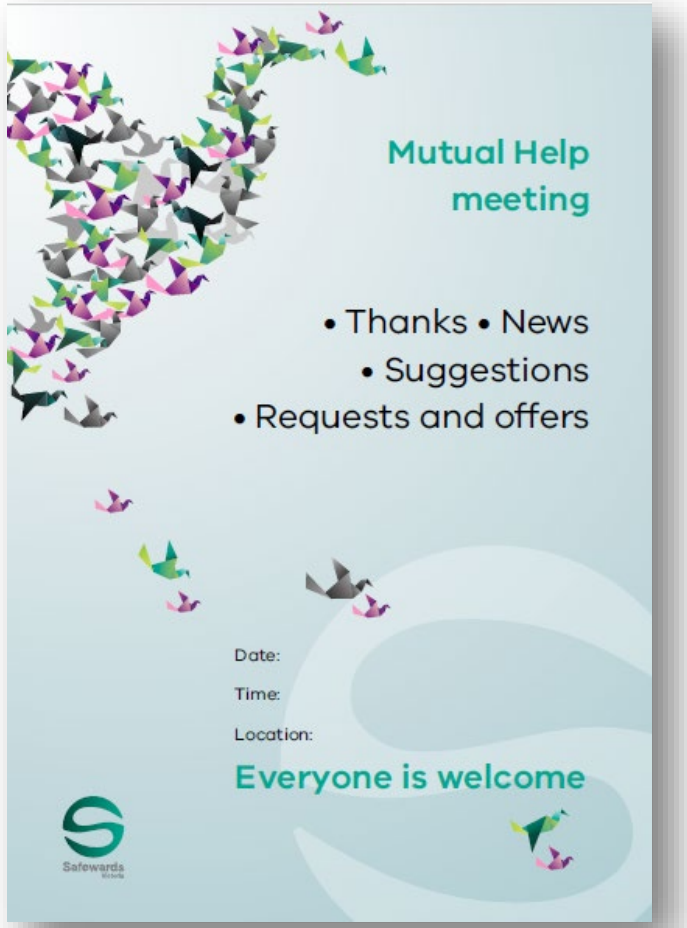
# Aims

When a patient is preparing to leave, there is an opportunity for them to provide a discharge message as a form of closure for themselves and to help others on the unit.

**Aims:**

- Provide authentic encouragement and support for new patients
- Provide hope and convey messages about the purpose and potential benefits of an admission
- Provide a boost to self-esteem / identity on leaving the unit through making a valued contribution to the patient community

# Mutual Help Meeting



# Background

- The unit is a social community and potentially a powerful engine to support patients, have a positive influence, and progress towards discharge
- The help that patients give each other can be highly valued and effective
- The giving of help and support between patients offers the giver:
  - a socially valued role
  - the chance to make a meaningful contribution
  - the potential to improve their self-esteem

# Aims

- Strengthen an existing mechanism that is highly valued by patients and staff
- Create opportunities for patients to find valued roles and public recognition

- Build patient self-esteem
- Increase mutual support and promote recovery
- Establish values, understanding and social connection

# Clear Mutual Expectations

# Lack of consistency and clarity can cause problems

Lack of consistency and clarity is annoying for almost everyone.

It may particularly affect those who:

- are distracted by distressing thoughts or emotions, or are preoccupied
- have difficulty interpreting communication
- have a distorted, or different view of the world and others
- have a history of trauma

# Background and aims

**Background**

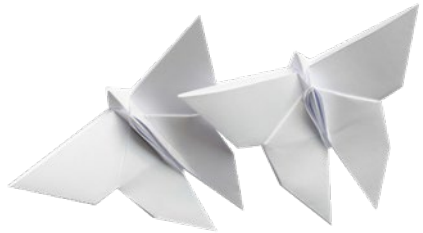
Some flashpoints, and therefore conflict, are due in part to unclear expectations, lack of clarity or inconsistency on the unit.

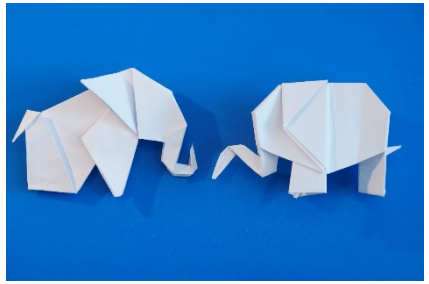
**Aims**

- Create a more egalitarian social unit
- Mutual holding to account
- Set clear standards for both staff and patients
- Build consistency and predictability while allowing flexibility
- Ensure patients and staff understand their obligations to each other

# 15min break – afternoon tea

# Activity Three



# Presentation 4:
# Group discussion with Lisa

# Final comments from Len…

- *If your intervention doesn't alter any of the 'staff modifiers' identified in the Safewards Model, then it isn't classified as a Safewards intervention*
- *Although many Safewards interventions can be done creatively, that doesn't mean anything creative or arty is a Safewards intervention*

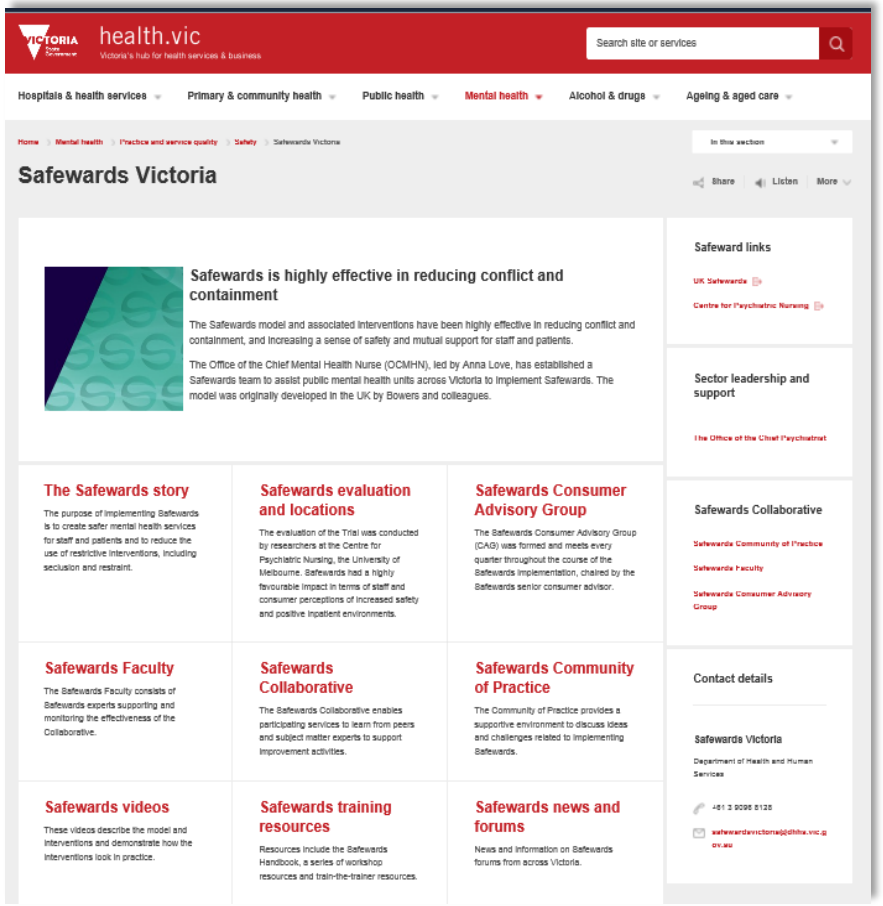
# Final comments from Len…

- *None of the interventions will work if you and your team do not actually do them!*
- *If you present an over-optimistic, exaggeratedly positive, all bad news removed story to your immediate manager, who does the same plus a bit extra to theirs, etc. then the people at the top think everything is wonderful and being put into effect, while in reality nothing much is happening on the wards at all*

# Congratulations and welcome…

# Sources

www.health.vic.gov.au/safewards




www.safewards.net/