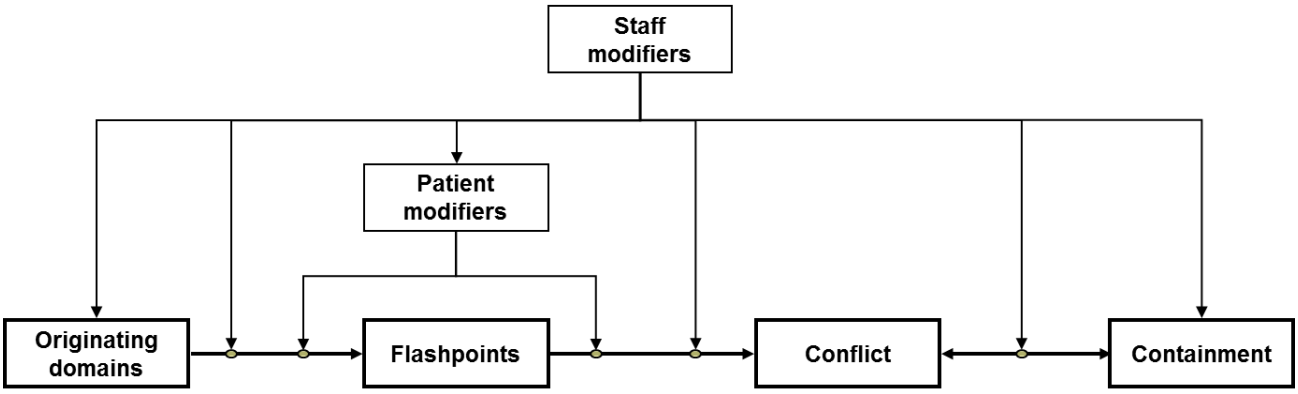
Safewards

Below is the most basic form of the Safewards Model, which summarises the factors influencing rates of conflict and containment on wards, and explains why some wards have ten times as much conflict and containment than others, even though they are in the same hospital and admit the same sorts of patients. By ***conflict*** we mean all those patient behaviours that threaten their safety or the safety of others (violence, suicide, self-harm, absconding etc.), and by ***containment*** we mean all the things staff do to prevent those events from occurring or seek to minimize the harmful outcomes (e.g. PRN medication, special observation, seclusion, etc.). Our model indicates that there are a set of ***conflict originating factors*** that can give rise to specific flashpoints which can then trigger a conflict incident. The model also indicates that containment is in a dynamic reciprocal relationship with conflict, and that sometimes the use of containment can itself give rise to conflict rather than successfully prevent it. Finally, the model shows that ***staff can influence rates of conflict and containment*** on their wards at every level: by reducing or eradicating the conflict originating factors; by preventing flashpoints from arising out of them; by cutting the link between the flashpoint and conflict, i.e. the flashpoint occurs but does not lead to a conflict event; by judiciously choosing not to use containment on occasions when it would be counterproductive; and by ensuring that containment use does not lead to further conflict when it is used.



Not shown in the simplified diagram above is that conflict originating factors arise out of six domains, and each of these domains provides for differing flashpoints and therefore differing ways for staff to intervene in order to promote greater safety and decreased containment. The following table provides a summary of these:

Domain/originating factors	Flashpoints	Staff modifiers
Staff team or Internal Structure: Rules; Routines; Efficiency, Clean/tidy; Ideology, custom & practice	Denial of request; Staff demand; Limit setting; Bad news; Ignoring	Staff anxiety & frustration; Moral commitments; Psychological understanding; Teamwork & consistency; Technical mastery; Positive

		appreciation
Physical environment: Door locked; Quality; Availability of seclusion; Rooms; PICU or comfort/chill/sensory rooms	Complexity of layout; Hidden areas; Private areas	Caringly vigilant & inquisitive; Checking routines
Outside hospital: Visitors; Relatives & family tensions; Prospective negative move; Dependency & Institutionalisation; Demands & home	Bad news; Home crisis; Loss of relationship or accommodation; Argument	Carer/relative involvement; Family therapy; Active patient support
The patient community or patient-patient interaction: Contagion & discord	Assembly/crowding/activity; Queuing/waiting/noise; Staff/pt turnover/change; Bullying/stealing/property damage	Explanation/information; Role modelling; Patient education; Removal of means; Presence & presence+
Patient characteristics, symptoms & demography: Paranoia, PD traits; Irritability/disinhibition; Abused; Male; Alcohol/drugs; Depression; Insight; Delusions; Hallucinations; Young	Exacerbations; Independence/identity; Acuity/severity	Pharmacotherapy; Psychotherapy; Nursing support & intervention
Regulatory framework or external structure: Legal framework; National policy; Complaints; Appeals; Prosecutions; Hospital policy	Compulsory detention; Appeal refusal; Complaint denied; Enforced treatment	Due process; justice; respect for rights; Information giving; Support to appeal; Legitimacy

The table above summarises a great deal of information about all the different ways in which both conflict and containment can arise, due to widely varying factors. To take just one example a rule that a patient cannot have, say, sharp objects in their property while they are on the ward, can give rise to an occasion on which they ask for some and are told no by the staff. If handled poorly by the staff, in a disrespectful fashion, against a background of previous inconsistent answers, this may prompt verbal aggression from the patient or worse. For internal structure, staff have some control over the content of the originating factor, therefore over whether flashpoints are likely to occur and whether those flashpoints are likely to turn into an adverse incident. The physical environment is

less malleable to staff, but how they work within that environment to deliver care and supervision is very much within their control. What happens outside the hospital within the patient's network of friends and family may not be alterable by staff, but staff can make sure they know about potential stressors, tensions and demands, and intervene quickly when these become acute or upsetting. Similarly, staff can act to shape and modify patients' interactions and responses to each other, by fostering a positive and non-judgmental approach through a variety of ways. Staff cannot choose a patient's symptoms or the contents of their delusions, however they can deliver good treatment in a supportive and low stress environment, promoting quick recovery. Efficient and effective treatment for mental illness is a conflict reducing measure. Finally, while the framework of the mental health act cannot be changed, the manner in which it is used by staff, and way in which power is exerted, can have a significant impact on how much conflict is generated.

It is clear from this model that no single small intervention is going to solve all problems and eliminate all conflict and containment. What is required is action on a multitude of different fronts. Even then, some of the conflict originating factors are obdurate realities, such as mental illness, legislation, etc. Nevertheless staff do have considerable power and influence over conflict and containment rates by the way in which they respond to these and other conflict generating factors.

Safewards: Ten Interventions

1. ***Clear Mutual Expectations*** – staff and patients agree on expectations from each other and put a laminated poster on the notice board; this is about acceptable and unacceptable behaviour.

2. ***Positive words*** – staff to acknowledge the positive during Handovers.

3. ***Soft words*** – message on office message boards to remind staff how to communicate in helpful ways.

4. ***Mutual Help meetings*** – staff and patients meet on set times to share news, say thank you, come up with suggestions, make requests or make an offer to help.

5. ***Bad news mitigation*** – put us in the shoes of the other and think how we convey difficult messages and what support is needed.

6. ***Talk down*** – talk and act in a way to decrease the tension.

7. ***Calm down*** – to make use of various methods to calm down e.g. music, stress balls, etc.

8. ***Know each other*** – patients and staff can share non-personal information such as hobbies, sports team to connect with each other by talking about interests that we share.

9. ***Reassurance*** – to support patients at times when they are stressed of something of concern happened and they are worried.

10. ***Discharge messages*** – patients who leave may want to write a message which can be displayed or the notice board and shared with new patients to give them hope.