Safewards *driven case scenario structured reflection aid*

Key question: what were the contributing factors associated with triggering or sustaining conflict behaviour or coercive intervention in this patient? **OR:** which factors were helpful in the successful de-escalation strategy used for this patient ?

Structure phase 1: please use this page for the analysis-round according the six Safewards domains described below. One participants prepares a summary of the current relevant patient characteristics and the symptoms or behaviors that need to be addressed and introduces this anonymously in maximum 5 minutes. If needed extra information is added by the other participants. In the next stage all participants scan the five other domain individually and make brief notes. (maximum 10 minutes). During the next 10 minutes the findings are shared and discussed led by one moderator resulting in an integrative working hypothesis or problem statement. Once this process is completed the group addresses to phase 2: the intervention considerations (please review the summary of the 10 core Safewards intervention at the next page. The maximum duration of this phase is 30 minutes.

DOMAIN	FLASHPOINTS	MODIFIERS
Patient characteristics Patient characteristics that are more likely to cause conflict. Such as: a range of possible symptoms, such as paranoia or hallucinations. Patients who have difficulties relating to other people. Age, gender, diagnosis, where patents live etc. Certain types of conflict are more likely for different groups. For example, younger men more likely to absconding from care than other groups.	Staff needing to guide patients by asking them to do something or stop doing something. Staff placing restrictions on patients. Perceived (or real) loss of liberty.	Staff offering best treatments in a timely manner. Staff offering explanations about condition. Compassionately managing those times when staff need to ask patients to do something or stop doing something.
Outside hospital Wards are not cut off from the world. Events and people off the ward have an effect. Money worries, arguments or concerns with family and friends do not disappear with admissions. Drugs and alcohol are available outside of hospital during leave and if a patient absconds. Also, patients are always aware that they will leave the ward eventually and return to the outside world.	Patients arguing with family and friends Patient dealing with divorce bereavement/ illness/ loss. Patients receiving bad news about people or events off the ward. Crisis at patients or loved one's home (debt, bills, fire, burglary, threat of eviction	Staff being familiar with and familiar to family and friends. Staff offering or signposting specific help for family and friends. Staff being aware of the issues patients have off the ward.
Patient community As wards are not immune from tension off the ward, so patients are not immune from tensions from other patients. Feelings can run high on wards were everyone is struggling to cope	Patients can be negatively affected by the feelings or behaviour of other patients. Some patients may be anxious or frustrated and much harder to deal with other people's behaviour.	Staff can model caring and understanding in managing difficult feelings or behaviour. Staff can make sure that patients have a chance to support each other in helpful ways.
Regulatory framework Both staff and patients are bound by legal and managerial policies. The Mental Health Act is law and has to be followed. Many hospital policies are written to ensure all wards stick to the same procedures and often comply with national guidance. This Domain give staff very real power over patients, but also very real responsibilities	When the realities of containment under the Mental Health Act cause tensions between patients and staff. Where staff are seen by patients to be abusing the power they have or not fulfilling their responsibilities.	Staff can be vigilant about ensuring patients have all their rights looked after. This includes giving patients information and helping with appeals or complaints. Where staff are as flexible as possible to compensate for very real restrictions.
Physical environment The nicer the ward is in terms of good quality furniture, equipment and general décor, the more comfortable patients will feel and the less conflict there is. Wards that have clear viewpoints with few hidden areas are generally safer. This domain also includes staff striking a healthy balance between needing to supervise patients and needing to give periods of privacy	Patients being isolated for long periods. Frustrations when furniture, equipment is broken or not fit for use, or when décor is drab and depressing. First few days of admission when there can be a sense of shock at the strangeness of the ward. When patients realize the door is locked (if it is) and they have to ask to leave, or are not allowed to leave.	Paying attention to repair and décor needs. Staff knowing where patients are and making active choices about allowing privacy or supervising. Staff offering time to patients, being aware of distress and not being frightened of checking if they think someone needs help or is coming to harm.
Team or internal Structure (This is about how staff deal with their own feelings. It's also about how they support each other to be consistent in setting and keeping to rules and how consistent they are in dealing with patients' needs. It is also reflected in how much the day to day routine of the ward is geared to being with patients and looking after their needs. This includes making sure the ward is clean and tidy.	When staff to set limits to patient behaviour. When staff tell patients information or news that is upsetting. If there are inconsistencies in staff approach to ward rules. If staff, for whatever reason, don't address to questions or needs.	Carefully and compassionately managing times when staff need to ask patients to do something or stop doing something. Also being able to compassionately break bad news to patients. Also how well staff work as a team to be consistent and clear.

Safewards core intervention overview *(Fletcher et al, 2019)*

Structure phase 2: please briefly review the intervention below and consider which intervention would be beneficial for the patient and/or the multidisciplinary team. Based on the group consensus a safety and recovery plan is composed using a number of the below listed interventions in a personalized way. Led by the moderator the group formulates realistic goals for the next 7 or 14 days and evaluate the outcomes in terms of learned lessons for similar cases in the future. These findings can be used in a dynamic fashion for a local Safewards manual. The maximum duration of this phase is 15 minutes.

INTERVENTION	DESCRIPTION	PURPOSE	HOW
Mutual Help Meetings	Patients offer and receive mutual help and support through frequent meetings	Strengthens patient community, opportunity to give and receive help	
Know Each Other	Patients and staff share some personal interests and ideas with each other, displayed in unit common areas	Builds connection, and sense of common humanity	
Clear Mutual Expectations	Patients and staff work together to create mutually agreed aspirations that apply to both groups equally	Counters some power imbalances, creates a stronger sense of shared community	
Calm Down Methods	Staff support patients to draw on their strengths and use/learn coping skills before the use of pro re nata medication or containment.	Strengthen patient confidence and skills to cope with distress	
Discharge Messages	Before discharge, patients leave messages of hope for other patients on a display in the unit	Strengthens patient community, generates hope	
Soft Words	tone and use of collaborative language. Staff reduce the limits faced by patients, create flexible options, and use respect if limit setting is unavoidable.	Reduces a common flashpoint, builds respect, choice, and dignity	
Positive Words	Staff say something positive in handover about each patient. Staff use psychological explanations to describe challenging actions.	Increases positive appreciation and helpful information for colleagues to work with patients	
Bad News Mitigation	Staff understand, proactively plan for. and mitigate the effects of bad news received by patients	Reduces impact of common flashpoints, offers extra support	
Reassurance	Staff touch base with every patient after every conflict on the unit and debrief as required	Reduces a common flashpoint, increases patients' sense of safety and security	
Verbal de-escalation (talk down)	De-escalation process focuses on clarifying issues and finding solutions together. Staff maintain self-control, respect, and empathy	Increases respect, collaboration, and mutually positive outcomes	

Derived and modified from: Fletcher J, Hamilton B, Kinner SA, Brophy L. Safewards Impact in Inpatient Mental Health Units in Victoria, Australia: Staff Perspectives. Frontiers in Psychiatry. 2019 Jul 10;10:462. doi: 10.3389/fpsyt.2019.00462. PMID: 31354541; PMCID: PMC6635577.