Overview: Safewards Model

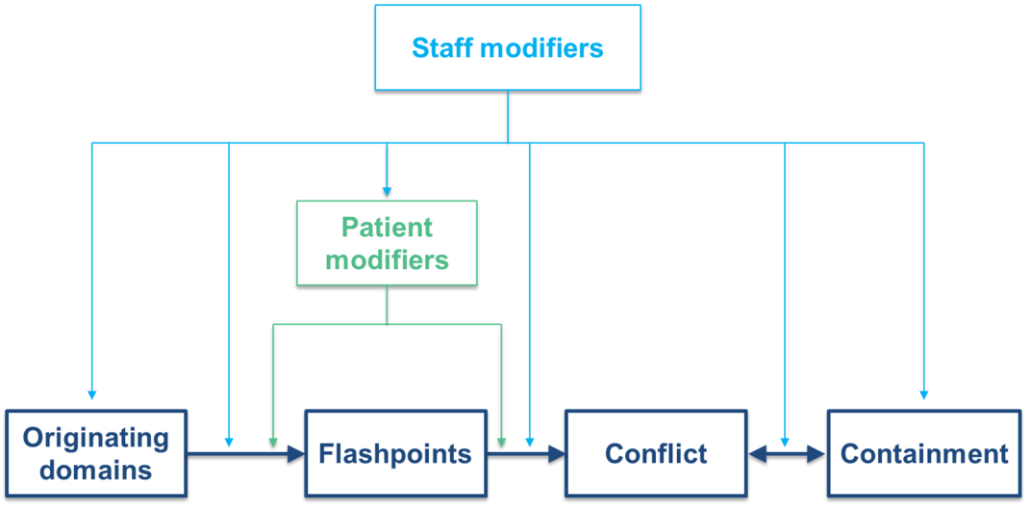
Safewards Victoria

Safewards was developed for inpatient mental health units by Professor Len Bowers (UK). Safewards aims to improve safety for both consumers and staff, with a focus on reducing **conflict** (anything that could be harmful for a patient, other patients, or staff) and **containment** (restrictive interventions).

Safewards has a strong and growing evidence base from the UK and here in Victoria. It includes an exploratory model and ten interventions.

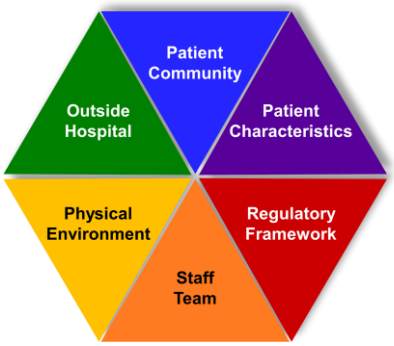
Staff and patient modifiers in the Safewards model identify opportunities to prevent conflict and containment, or reduce its impact. The Safewards interventions provide practical ways to use these modifiers. The interventions are preventative actions that are taken to increase safety and mutual support for staff and patients.

The Simple Safewards Model



Originating domains

There are six originating domains, and they represent different aspects of inpatient units that affect conflict and containment (see below). Research tells us these domains can create potential flashpoints.



Safewards originating domains

Flashpoints

Flashpoints are times or situations when things could go wrong. They arise out of the originating domains, and they're like 'triggers' or 'tipping points' that signal and precede potential conflict.

Staff can prevent flashpoints by understanding and responding to domains before there is a problem.

Staff can reduce the likelihood of conflict and containment by how they respond to flashpoints. Even if conflict occurs, staff can use strategies other than restrictive interventions.

This information was adapted from material developed by Professor Len Bowers, UK.

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Overview: Safewards Interventions

Safewards Victoria

The Safewards model and approach to care identifies these ten interventions. Each intervention is explained in more detail on the Safewards Victoria website: www.health.vic.gov.au/safewards

Know Each Other

Patients & staff share some personal interests & ideas with each other, displayed in unit common areas.

Builds rapport, connection & sense of common humanity

Clear Mutual Expectations

Patients & 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

Positive Words

Staff speak positively in handover about each patient. Staff use psychological explanations to describe challenging actions.

Increases positive appreciation & helpful information for colleagues to work with patients

Discharge Messages

Before discharge, patients leave messages of hope for other patients on a display in the unit.

Strengthens patient community
Generates hope

Mutual Help Meeting

Patients offer & receive mutual help & support through a daily, shared meeting.

Strengthens patient community
Opportunity to give & receive help

Reassurance

Staff debrief every patient after every conflict on the unit.

Reduces a common flashpoint, increases patients' sense of safety and security

Bad News Mitigation

Staff understand, proactively plan for & mitigate the effects of bad news received by patients.

Reduces impact of common flashpoints, offers extra support

Soft Words

Staff reduce the limits faced by patients, create flexible options & use respect if limit setting is unavoidable.

Reduces a common flashpoint
Builds respect, choice & dignity

Calm Down Methods

Staff support patients to draw on their strengths & use/learn coping skills before the use of PRN medication or containment.

Strengthen patient confidence & skills to cope with distress

Talk Down Methods

De-escalation process focuses on clarifying issues and finding solutions together. Staff maintain self-control, respect & empathy.

Increases respect, collaboration and mutually positive outcomes

This information was adapted from material developed by Professor Len Bowers, UK.