SUPPLEMENTARY MATERIALS 3: INTERVENTION DEVELOPMENT

A5-A10

SM3.1 Expert stakeholder-generated ideas to improve de-escalation capability and motivation by enhancing skills, knowledge, and attitudes

Intervention component	***Theoretical domains and behaviour change targets***	***Delegate recommendations for enhancing capabilities, opportunities, and motivation and intervention format, content and delivery methods***
1.De-escalation training	Knowledge 1.Trauma education 2.Personality disorder education Skills 5.Therapeutic engagement with voices 6.Relationship and engagement skills 7.De-escalation skills Social influences 9.Understanding of behaviourist principles in the context of trauma 12.Attributions and moral judgements Emotion 8.Enhanced emotion regulation	Because of the prominence of trauma knowledge in determining de-escalation capability in WP1 data, feedback indicated that training addressing all related BCTs (whether skill or knowledge-related) should have trauma education/ trauma-informed care as its underpinning philosophical orientation. The training was felt to need a minimum of eight hours, face-to-face training refreshed annually with learning integrated with regular reflective practice. Service users and carer researchers should lead the training with support by Trust Reducing Restrictive Practice Instructors.
2. Conflict formulation	Skills 7.De-escalation skills Social influences 9.Understanding of behaviourist principles in the context of trauma 12.Attributions and moral judgements 13.Role-modelling of de-escalation and attendant values Emotion 8.Enhanced emotion regulation	Because of the prominence of moral judgements as a barrier to understanding patients and emotion regulation, the need for novel ways of formulating conflict was emphasized. Needs-based analysis of behaviour was recommended as a useful way of undermining moral formulations and developing staff understanding. Formulation of staff as well as patient emotional inputs was felt useful. As such the need for formulation of 'conflict' rather than 'patients' was emphasized. It was felt reflective practice models should be led by clinical psychologists owing to the sensitivity of the topics and the need to contain the difficult emotions that may arise from the sessions. Feedback indicated that weekly reflective practice was the optimal frequency for staff.
3. Reclaiming narratives (reflective groups targeted at patients)	Social influences 14.Tolerance of patient dissent/ criticism Reinforcement 43. Enhance patient knowledge, skills and confidence in challenging poor practice	To address the BCTs *'Tolerance of patient dissent/ criticism'* and *'Enhance patient knowledge, skills and confidence in challenging poor practice'* a reflective group for patients was recommended. This should enhance patient ability to collectivise and resolve conflicts with staff, have their needs met and enhance empathy between staff and patients. It was felt reflective practice models should be led by clinical psychologists owing to the sensitivity of the topics and the need to contain the difficult emotions that may arise from the sessions. Feedback indicated that reflective groups for patients should occur fortnightly.

4.'Negotiated boundaries'	Skills 6.Relationship and engagement skills 7.De-escalation skills Social influences 9.Understanding of behaviourist principles in the context of trauma 10.Mutual support in staff team 11.Attitudes to vulnerability in staff team 13.Role-modelling of de-escalation and attendant values Social/ professional role & identity 41.Reflection on professional boundaries and role perceptions Emotion 8.Enhanced emotion regulation	The psychologist delegates within the clinical expert group proposed an additional novel model of reflective practice. To promote reflection on blanket boundary setting both in terms of limits set on patient behaviour and in terms of limits set on appropriate levels of intimacy in staff-patient relationships, it was felt useful to encourage staff to determine which of their own behaviours, as well which patient behaviours, were permissible in the environments they work in. They recommended the development of card sets with a range of staff and patient behaviours depicted on them. Then asking clinical staff to sort the cards into 'negotiable' and non-negotiable categories. Where behaviours were rated as non-negotiable, a discussion should take place as to what the specific need is that the boundary protects, who's need it protects (staff or patient), potential alternatives and if, necessary, skills necessary to safely implement the boundary. It was further highlighted that this process could also be used to promote reflection on attitudes to, and protection of, vulnerability in colleagues. It was felt reflective practice models should be led by clinical psychologists owing to the sensitivity of the topics and the need to contain the difficult emotions that may arise from the sessions. Feedback indicated that weekly reflective practice was the optimal frequency for staff.

SM3.2 Expert stakeholder-generated intervention ideas to create opportunities for de-escalation by changing power dynamics

Intervention component	***Theoretical domains and behaviour change targets***	***Delegate recommendations for enhancing capabilities, opportunities, and motivation and intervention format, content and delivery methods***
5.Patient handover	Social influences 14.Tolerance of patient dissent/ criticism Environmental context and resources 18.Quality and objectivity of nursing notes describing patient behaviour 27.Management of patient requests 39.Service user involvement in handover	A process to involve patients in handover was recommended to improve the quality and objectivity of communication at handover. It was suggested this could be safely achieved by collecting a direct quote from each patient prior to handover, which would then be read out verbatim at each handover. It was suggested a member of nursing staff could lead this process.
6.Ward rounds	Environmental context and resources 40.Reducing ward round-related anxiety	The need to reduce service user distress arising from ward rounds was emphasized by all stakeholder groups. More work by the research team was recommended to identify what the key sources of distress are. Because psychiatrists were regarded as having the most influence in terms of ward round format and delivery, they were recommended as intervention leads for any proposed intervention.
7.Insiders' guides and welcoming committee	Environmental context and resources 19.Admission experience (social isolation and use-of-force) 35.Modify patient perceptions of environments as prisons 36.Patient community conflict	The need to reduce patient experience of social isolation and use of force was identified by all stakeholder groups of importance to enhanced de-escalation. Service-led ward information booklets and the establishment of a welcoming committee comprised of nursing staff, domestic staff and patients was recommended. It was recommended the nursing staff and patients lead this intervention.
8.Collaborative antipsychotic prescribing	Social influences 16.Collaborative antipsychotic prescribing	All stakeholder groups emphasised the importance of improved collaboration in prescribing. They perceived this as a potentially important way of reducing restrictive intervention resulting from medication-related conflict. Improving communication with patients around medication decisions was additionally seen as a means of improving relationships between medical and nursing staff. Limited feedback was received on either the format and delivery of an intervention but work on collaborative prescribing at the University of Manchester (113) was highlighted. Psychiatrists should lead this intervention.

SM3.3 Expert stakeholder-generated intervention ideas to create opportunities for de-escalation by changing the environment

Intervention component	***Theoretical domains and behaviour change targets***	***Delegate recommendations for enhancing capabilities, opportunities, and motivation and intervention format, content and delivery methods***
9.Sensory modulation and support planning	Skills 7.De-escalation skills Behavioural regulation 4.Advance de-escalation planning Environmental context and resources 34.Implementation of sensory modulation 36.Patient community conflict Emotion 8.Enhanced emotion regulation	Delegate feedback emphasised there should be new systems of support planning which educate patients and staff about the role of sensory modulation in de-escalation. Development of support planning proformas should be service user-led and incorporate options for providing space (passive or deferred intervention) as well as active intervention. Support plans should be owned by service users and kept in their possession where possible. Support plans should be hard copies and not only stored on computers so that all staff including non-regular staff can access them. Sensory rooms should be created, and equipment purchased. Access to service users should be maximised as far as possible and utilised as a preventive as well as reactive measure. It was felt that occupational therapists should lead this intervention.
10.Boxing	Environmental context and resources 28.Stimulating, age-appropriate and voluntary structure of activities 34.Implementation of sensory modulation	Because of the value ascribed to it by patients in WP1 data, and, because of clinical and service user expert experiences of its value, making boxing equipment available to patients was proposed. It was highlighted that this intervention may additionally help to address the WP1 finding that patients currently experience sensory modulation as neither age nor gender appropriate. To ensure safety, delegates identified occupational therapy and physiotherapy oversight of this intervention as essential.
11.Patient-reported audit tool	Social influences 14.Tolerance of patient dissent/ criticism 15.Tolerant and flexible regimes Environmental context and resources 17.Environmental signifiers of coercion and disrespect 27.Management of patient requests 32.Staff presence in communal areas	Delegates recommended that all WP1 data relating to aspect of the environment that conflict with de-escalation should be synthesised into a patient led audit tool. A service user (who has capacity to undertake the role) should audit environments once every two weeks. The intervention should be service user-led with supervision and support by a member of nursing staff.

SM3.4 Expert stakeholder-generated intervention ideas to create opportunities for de-escalation by changing clinical systems and the organisational context

Intervention component	***Theoretical domains and behaviour change targets***	***Delegate recommendations for enhancing capabilities, opportunities, and motivation and intervention format, content and delivery methods***
12.Debriefing	Behavioural regulation 3.Post-incident debriefing Social influences 13.Role-modelling of de-escalation and attendant values 10.Mutual support in staff team 12.Attributions and moral judgements (and reflection in language) 9.Understanding of behaviourist principles in the context of trauma Environmental context and resources 20.Closer working relationships between nursing leadership and ward staff 21.Feedback mechanisms that increase visibility of critical events 22.Reduced blame, increased accountability Emotion 8.Enhanced emotion regulation	Post-incident debriefing incorporating needs-based analysis was recommended. Should take place after every incident of seclusion and restraint and involve elicitation of staff and patient perspectives. Options for written proformas and face-to-face meetings. Effective mechanisms for diffusion of learning throughout organisations needed. Intervention should be led by nursing leadership and attended by ward managers to improve clinical input from leaders and role-modelling of de-escalation and attendant values.
13.. Feedback intervention	Reinforcement 42.Formalisation of thanks and appreciation of de-escalation practice 43.Enhance patient knowledge, skills and confidence in challenging poor practice Emotion 8.Enhanced emotion regulation Social influences 14.Tolerance of patient dissent/ criticism Environmental context and resources 20.Closer working relationships between nursing leadership and ward staff 21.Feedback mechanisms that increase visibility of critical events 22.Reduced blame, increased accountability 23.Open dialogue (culture of critical discussion of practice)	Increase the meaningfulness of feedback on practice by providing opportunities for anonymous patient and staff feedback on conflict, de-escalation and safety. Locked feedback boxes to be installed in discrete staff and patient areas. Feedback to be collected by senior nurses (e.g., operational managers, modern matrons) then reviewed with staff teams once per month.
14.. Just & Learning website	Environmental context and resources 22.Reduced blame, increased accountability 25.Positive risk-taking strategy.	Expert stakeholders proposed a dedicated website offering examples of non-blaming incident investigations and tangible evidence of changes in senior leaderships' responses based on prior incidents. The website will also highlight the Trust's positive risk-taking strategy and the distinction between a just and learning culture and a neglectful culture will be presented. A senior clinical nurse, at operational manager level or above will be responsible for creating,

		updating and signposting staff to the website.

SM3.5 Expert stakeholder-generated intervention ideas to create opportunities for de-escalation by changing attitudes to vulnerability within staff teams

Intervention component	***Theoretical domains and behaviour change targets***	***Delegate recommendations for enhancing capabilities, opportunities, and motivation and intervention format, content and delivery methods***
15.Safety huddles	Skills 7.De-escalation skills Social influences 13.Role modelling of de-escalation and attendant values 11.Attitudes to vulnerability in staff team 10.Mutual support in staff team Emotion 8.Enhanced emotion regulation	Safety huddles were recommended as a means of improving teamwork in de-escalation and enhancing emotion regulation in all members of staff especially more vulnerable members of the team (e.g. new starters, non-regular staff). This should take the form of meetings at the beginning and the middle of each shift and should be led by ward managers to facilitate role modelling.
16.Protection of non-regular staff	Skills 7.De-escalation skills Social influences 13.Role modelling of de-escalation and attendant values 11.Attitudes to vulnerability in staff team 10.Mutual support in staff team Environmental context and resources 30.Brief on ward training of non-regular staff Emotion 8.Enhanced emotion regulation	Recommended measures to provide greater protection of non-regular staff and student nurses including orienting materials and brief induction to the ward, in terms of its values, what they can expect and expectations of their behaviour and engagement with patients. Buddy systems for new starters were also recommended. This intervention should be led by ward managers to facilitate role modelling.

SM3.6 Service user researcher, carer researcher, and RRPI-delivered components, mapped to theoretical domains, behaviour change targets, and behaviour change techniques

Intervention component	**Behaviour change target by COM-B and theoretical domain**				**Behaviour change technique grouping according to Behaviour Change Techniques Taxonomy**		
	Capabilities		***Opportunities***	***Motivation***			
	Knowledge	*Skills*	*Social influences*	*Emotion*	*4. Shaping Knowledge*	*6.Comparison of behaviour*	*11. Regulation*
1. De-escalation training	1.Trauma education 2. Personality disorder education	5.Therapeutic engagement with voices 6.Relationship and engagement skills 7.De-escalation skills	9.Understanding of behaviourist principles in the context if trauma 12. Attributions and moral judgements	8.Enhanced emotion regulation	4.1 Instruction on how to perform the behaviour 4.2 Information about antecedents 4.3 Re-attribution	6.1 Demonstration of the behaviour 6.3 Information about others' approval	11.2 Reduce negative emotions

SM3.7 Psychology-delivered components, mapped to theoretical domains, behaviour change targets, and behaviour change techniques

Intervention component	**Behaviour change target by COM-B and theoretical domain**				**Behaviour change technique grouping according to Behaviour Change Techniques Taxonomy**							
	Capabilities	***Opportunities***	***Motivation***									
	Skills	*Social influences*	*Emotion*	*Social/ professional role & identity*	*1. Goals and planning*	*2. Feedback and monitoring*	*3. Social support*	*4.Shaping knowledge*	*6. Comparison of behaviour*	*8. Repetition and substitution*	*11. Regulation*	*13. Identity*
2. Conflict formulation	7.De-escalation skills	9.Understanding of behaviourist principles in the context if trauma 10. Mutual support in staff team 12. Attributions and moral judgements 13. Role-modelling of de-escalation and attendant values	8.Enhanced emotion regulation		1.4 Action planning	2.2 Feedback on behaviour	3.2 Social support (practical) 3.3 Social support (emotional)	4.2 Information about antecedents 4.3 Re-attribution	6.1 Demonstration of the behaviour 6.3 Information about others' approval	8.3 Habit formation 8.4 Habit reversal	11.2 Reduce negative emotions	13.1 Identification of self as role model
3. Negotiated boundaries	6.Relationship and engagement skills 7. De-escalation skills	9.Understanding of behaviourist principles in the context if trauma 10. Mutual support in staff team 11. Attitudes to	8.Enhanced emotion regulation	41. Reflection on professional boundaries and role perceptions	1.4 Action planning	2.2 Feedback on behaviour	3.2 Social support (practical) 3.3 Social support (emotional)	4.2 Information about antecedents 4.3 Re-attribution	6.1 Demonstration of the behaviour 6.3 Information about others' approval	8.3 Habit formation 8.4 Habit reversal	11.2 Reduce negative emotions	13.1 Identification of self as role model 13.2 Framing/ reframing 13.3 Incompatible beliefs

		vulnerability in staff team 13. Role-modelling of de-escalation and attendant values										13.4 Valued self-identity

SM3.8 Senior nurse-delivered components, mapped to theoretical domains, behaviour change targets, and behaviour change techniques

Intervention component			**4. Debriefing**	**5. Symmetrical feedback**
Behaviour change target by COM-B and theoretical domain	***Capabilities***	*Behavioural regulation*	3. Post-incident debriefing	
		Social influences	9. Understanding of behaviourist principles in the context of trauma 10.. Mutual support in staff team 12. Attributions and moral judgements 13. Role-modelling of de-escalation and attendant values	14.Tolerance of patient dissent/ criticism
	Opportunities	*Environmental context and resources*	20. Closer working relationships between nursing leadership and ward staff 21. Feedback mechanisms that increase the visibility of critical events 22. Reduced blame, increased accountability	20. Closer working relationships between nursing leadership and ward staff 21. Feedback mechanisms that increase the visibility of critical events 22. Reduced blame, increased accountability 23. Open dialogue (culture of critical discussion of practice)
	Motivation	*Emotion*	8. Enhanced emotion regulation	8. Enhanced emotion regulation
		Reinforcement		42. Formal thanks and appreciation of good practice 43.Enhance patient knowledge, skills and confidence in challenging poor practice
Behaviour change technique grouping according to Behaviour Change Techniques Taxonomy		*1.Goals and planning*	1.4 Action planning	1.4 Action planning
		2.Feedback and monitoring	2.2 Feedback on behaviour	2.2 Feedback on behaviour
		3.Social support	3.2 Social support (practical) 3.3 Social support (emotional)	3.2 Social support (practical)
		4.Shaping knowledge	4.2 Information about antecedents 4.3 Re-attribution	
		6.Comparison of behaviour	6.1 Demonstration of the behaviour 6.3 Information about others' approval	6.3 Information about others' approval
		8.Repetition and substitution	8.3 Habit formation 8.4 Habit reversal	8.4 Habit reversal
		10. Reward and threat		10.4 Social reward

	11. Regulation	11.2 Reduce negative emotions	11.2 Reduce negative emotions
	12. Antecedents		12.2 Restructuring the social environment
	13. Identity	13.1 Identification of self as role model	13.1 Identification of self as role model 13.2 Framing/ reframing 13.3 Incompatible beliefs 13.4 Valued self-identity

SM3.9 Ward team and patient-delivered components, mapped to theoretical domains, behaviour change targets, and behaviour change techniques

Intervention component	**Behaviour change target by COM-B and theoretical domain**		**Behaviour change technique grouping according to Behaviour Change Techniques Taxonomy**			
	Opportunities					
	Social influences	*Environmental context and resources*	*2. Feedback and monitoring*	*4.Shaping knowledge*	*8. Repetition and substitution*	*12. Antecedents*
6. Patient handover	14. Tolerance of patient dissent/ criticism	18. Quality and objectivity of nursing notes describing patient behaviour 27. Management of patient requests 39. Service user involvement in handover			8.3 Habit formation	12.2 Restructuring the social environment
7. Insiders' guide and welcoming committee		19. Admission experience 35. Modify patient perceptions of environments as prisons 36. Patient community conflict			8.3 Habit formation	12.2 Restructuring the social environment
8. Patient-reported environmental audit tool	14. Tolerance of patient dissent/ criticism 15. Tolerant and flexible regimes	17. Environmental signifiers of coercion and disrespect 27. Management of patient requests 32. Staff presence in communal areas	2.2 Feedback on behaviour	4.2 Information about antecedents	8.3 Habit formation 8.4 Habit reversal	12.2 Restructuring the social environment

SM3.10 Occupational therapy-delivered components, mapped to theoretical domains, behaviour change targets, and behaviour change techniques

Intervention component	**Behaviour change target by theoretical domain**				**Behaviour change technique grouping according to Behaviour Change Techniques Taxonomy**					
	Capabilities		*Opportunities*	*Motivation*						
	Skills	*Behavioural regulation*	*Environmental context and resources*	*Emotion*	*1. Goals and planning*	*2. Feedback and*	*4.Shaping knowledge*	*8.Repetition and*	*11. Regulation*	*12. Antecedents*

						monitoring		*substitution*		
9. Sensory modulation and support planning	7. De-escalation skills	4. Advance de-escalation planning	34. Implementation of sensory modulation 36. Patient community conflict	8. Enhanced emotion regulation	1.4 Action planning	2.2 Feedback on behaviour	4.1 Instruction on how to perform the behaviour 4.2 Information about antecedents 4.3 Re-attribution	8.3 Habit formation 8.4 Habit reversal	11.2 Reduce negative emotions	12.1 Restructuring the physical environment 12.5 Adding objects to the environment

SM3.11 Psychiatry-delivered components, mapped to theoretical domains, behaviour change targets, and behaviour change techniques

Intervention components	**Behaviour change target by theoretical domain**		**Behaviour change technique grouping according to Behaviour Change Techniques Taxonomy**		
	Opportunities				
	Social influences	*Environmental context and resources*	*4. Shaping knowledge*	*8. Repetition and substitution*	*12. Antecedents*
10. Manchester Collaborative Prescribing Approach	16. Collaborative antipsychotic prescribing		4.2 Information about antecedents	8.3 Habit formation 8.4 Habit reversal	12.2 Restructuring the social environment
11. Ward round standards		40. Reducing ward round-related anxiety	4.2 Information about antecedents	8.3 Habit formation 8.4 Habit reversal	12.2 Restructuring the social environment

SM3.12 Example debriefing chart (not a real scenario)

Process	Staff data	Patient data
Description of relevant behaviour/s	Use of physical restraint	Punched staff x3
Feelings Emotions preceding protective/ acquisitive behaviour.	**Frightened, anxious**	**Terrified, frightened**
Needs Unmet needs signalled by relevant feelings.	**Safety, protection from harm**	**Safety, security**
Salient context factors Situation/ environments factors triggering feelings and needs.	**Routine:** Occurred during application of general observations. **Time of day/ shift:** Night shift, patient was preparing for bed.	**Staff behaviour:** Did not knock before entering, did not identify self or explain actions. **Memories:** Staff behaviour (entering room at bed time) and characterisitics (age, gender, voice tone) of involved staff member triggered re-experiencing of abuse experiences. **Environment:** Bedroom door was left ajar which makes the patient feel unsafe. **Time of day/shift:** Nightime was when abuse experiences occurred.
Needs-based action plan Plans to meet unmet needs by changing the context of care/ working environment	**Staff and patient need for safety, security and protection from harm may be met by the following actions:** • Improving staff communication during the application of routine observations. • Ensuring the triggers for traumatic memories (e.g. time (night), location (bedroom) staff gender (male), routine (general observations) and environment (door left open) are recorded in patient's support plan. • Integrate support plan with observation schedule to ensure consistent practice. • Arrange restorative meeting between patient and staff to reduce mutually perceived threat.	

SM3.13 Items of the patient-reported environmental audit tool

	Never True	Sometimes True	Often True	Always True
Social environment				
1. There are staff outside of the ward nursing office	1	2	3	4
2. Patients are invited into clinics at medication times (rather that receiving medicines over the 'stable door')	1	2	3	4
3. The door to the ward nursing office is open	1	2	3	4
4. Patients aren't kept waiting a long time to have their requests met	1	2	3	4
5. When staff promise to talk to patients later, they remember to do so	1	2	3	4
6. There have been no arguments over 'PRN' (as needed or extra) medicines	1	2	3	4
7. Staff use of side rooms has not been prioritised over patients	1	2	3	4
8. There are on-ward activities for patients to take part in if they want to	1	2	3	4
9. Patients are free to access all ward areas (no shared rooms have been made 'out-of-bounds' to patients)	1	2	3	4
10. Patients and staff eat meals together	1	2	3	4
11. Patients know what 'sensory modulation' means	1	2	3	4
12. Patients know what sensory equipment the ward has and can access it when they want to	1	2	3	4
13. There have been no arguments over use of ward telephones	1	2	3	4
14. There have been no arguments over use of social media	1	2	3	4
15. There have been no arguments about opportunities to smoke	1	2	3	4
Physical environment				
16. The ward is neither too hot nor too cold	1	2	3	4
17. Messages displayed in ward areas don't threaten or instruct patients about their behaviour i.e., there are no 'respect us' posters, no 'staff only' posters, no 'please knock' posters or posters stating a policy of 'zero tolerance' to aggressive behaviour.	1	2	3	4
18. Staff make the environment look clean, tidy and homely	1	2	3	4
Please comment here about other issues that need to be addressed to make the ward peaceful place				

SM3.14 Signs I need support or space

Signs that I need support or space	**Support**	**Space**
When I isolate myself		
When I make drastic changes to my appearance		
When I lose my normal sleep pattern		
When I stop looking after myself (appearance, hygiene)		
When I seem worried and anxious		
When I seem sad or desperate		
When I threaten others		
When I say I'm going to harm myself		
When I say I'm going to abscond		
When I am shouting loudly		
When I become argumentative or demanding of others		
When I seem restless, like I can't sit still		
When I make rash decisions		
When I make sexual comments, remarks or gestures that are out-of-character for me		
When I say paranoid things about others		
When I am shouting loudly at my voices		
When I speak in an accent that is not my own		
When I change my eating or drinking habits		
Other signs I need support or space		

SM3.15 List of adverse effects derived from LUNSERS version 3 (127)

Instructions: Pick the 5 side effects that you most want to avoid. Then number them from 1 (most want to avoid) to 5 (least want to avoid). If there are any that would be helpful, tick them (or example, sleepiness at night if you have poor sleep or weight loss if you want to lose weight).

Sleepy	
Tired	
Difficulty getting off to sleep	
Increased dreaming	
Weight gain	
Weight loss	
Feeling sick	
Over-wet or drooling mouth	
Dry mouth	
Constipation	
Risk of high blood sugar / diabetes	
Risk of high cholesterol	
Less sex drive	
Difficulty getting an erection or having an orgasm	
Periods stopping, less often or not regular	
Increased sweating	
Difficulty passing urine	
Blurred vision	
Difficulty remembering things	
Tense or stiff muscles	
Slow movements	
Shaking or tremor	
Muscle spasms	
Parts of the body restless, seem to move by themselves (e.g. feet)	
Small risk of abnormal movements (30 per million per day)	
Dizziness when standing up	
Higher blood pressure	
Sensitivity to sun	
Noticing your heart beating fast	
Small risk of heart problems (risk of severe ones: 0 to 3 per million per day)	

SM3.16 Table of Antipsychotic Adverse Effects

SGA FGA	prolactin	sedation	weight gain	DM/lipids	EPSE	Antichol.	constipation	hypotension	QTc/SCD
Aripirpazole	-	insomnia+	+/-(nausea+)	-	**+/-(Ak++)**	-	-	-	-
Lurasidone	++	+	+/-(nausea+)	+/-	**+ (Ak++)**	-(saliva+)	-	-	-
Asenapine	-	++/+	+	+/-	+/-	-	-	-	++/-
Amisulpride	++++	-	+	+	+/-	-	+/-	-	+++
Sulpiride	++++	-	+	+	+	-	+	-	**++/+?**
Iloperidone	+/-	+/-	+++/++	+	+/-	-	-	+	++
Paliperidone	+++	+/-	++/+	**++?**	+	-	+/-	+	+/-
Risperidone	+++	+	++	++	+	-	+	++/+	++
Quetiapine	-	++	++	++	-	+	+/-	++	++
Pimozide	++	+/-	+	-	+	+	+	+	++++
Trifluoperazine	++	+	+	+/-	+++	+/-	+	+	++/+
Haloperidol	++	+	+/-	+/-	+++	+	++/+	+	**+++/++?**
Benperidol	++	+	+	+/-	+++	+	++	+	**+++?**
Flupentixol	++	+	++/+	+	+++/++	++	++/+	+	+/-
Perphenazine	++	++/+	+	+/-	**+++/++(Ak)**	-	+	+	+
Fluphenazine	++	+	+	+	++	++	++/+	+	++
Zuclopentixol	++	++	++	+	++	++	+	+	**++?**
Loxapine	++	++	+	+	+++	+	++	++	**+/-?**
Pericyazine	++	+++	++/+	**+?**	++/+	++	++	++	**+++?**
Olanzapine	+	++	+++	+++	+/-	+	+/-	+	**+++/++?**
Zotepine	++	+++	+++	**+?**	++/+	++(saliva+)	++/+++	++	**++?**
Chlorpromazine	+	+++	+++/++	++/+	++	++	+++	+++	**+++/++?**
Levomepromazine	++	+++	++	**++/+?**	+++(Ak)	+++/++	+++	+++	**+++/++?**
Clozapine	-	+++	+++	+++	-	+++	++++	+++	++

SM3.17 Example of four antipsychotic cards

• Erection problems / Periods stop +++ • Extremely rare heart problems (1 in 2500 per year?) *Note:* + uncommon or mild; ++ commoner or moderately severe; +++ common or more severe.	• Sleepiness ++ • Hunger / Weight gain + *Note:* + uncommon or mild; ++ commoner or moderately severe; +++ common or more severe.
• Poor sleep++ • Restlessness ++ • Feeling sick, not hungry + *Note:* + uncommon or mild; ++ commoner or moderately severe; +++ common or more severe.	• Stiff muscles, slow movements, tremor +++ • Erection problems / Periods stop ++ • Constipation ++ • Hunger / Weight gain + • Sleepiness + *Note:* + uncommon or mild; ++ commoner or moderately severe; +++ common or more severe.

SM3.18 Ward round standards

Ward round standards

1) Pre-ward round meeting with member of nursing staff to elicit perspectives and priorities.
2) Patients must be given as precise time for their ward round as possible (i.e., not the time-period the ward round will occur in) e.g.:
    a. Provide an exact time (even if this must be subsequently delayed).
    b. Provide sequence of attendees.
    c. Display a board in the ward round, showing the ward round's current progress in the sequence of attendees and any current or anticipated delays.
3) Presence of attending staff should be kept to an absolute minimum unless specific patient consent is given. The patient's first ward round should only be the consultant psychiatrist and the patient's named nurse/nursing representative.
4) At the start of the ward round, a round of introductions should be made where every professional is required to justify why they are attending.
5) Ward round attendees should be offered the opportunity to use first name terms with all present if this is their preference.
6) The ward round should start rather than end with the patient's perspective.
7) The ward round should not involve assessment of mental state and questions about symptoms.
8) Medical jargon and pathologizing language e.g. 'splitting' is not used.
9) Allow patients access to ward round records and the power to negotiate additions to them.
10) Doctors will personally escort each patient back to the ward area and ensure a brief handover to nursing staff is provided.