THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE

Agenda Reference:	Item No: 7
Date of Meeting:	12 August 2021
Presented by:	Director of Nursing and Allied Health Professions
Title of Report:	Scottish Patient Safety Programme Report July 2020 – June 2021

Table of Contents

1 Core Purpose of Service/Committee

The Scottish Patient Safety Programme plays a key role in the delivery of the 'Safe' ambition of the national Quality strategy:

"*... no avoidable injury or harm to patients from healthcare they receive, and an appropriate clean and safe environment will be provided for the delivery of healthcare services at all times.*"

The Scottish Patient Safety Programme for Mental Health (SPSP-MH) is a programme with an overall aim of reducing the harm experienced by individuals in receipt of care from mental health services, with a focus on adult psychiatric inpatient units (and forensic inpatient units) including admission and discharge processes.

The State Hospital continues to influence nationally through developing, implementing and sharing our SPSP – MH programmes of activity.

Existing Patient Safety Programmes generally focus on reducing unintended physical injury resulting from clinical care. In mental health services, harm may also occur that the service user causes to themselves or to others. This is nearly always the result of a complex interaction between patient factors, their mental illness, staff factors, their treatment, and their environment.

An initial scoping exercise, undertaken nationally, revealed a lack of clear evidence about what interventions might reduce harm in mental health. The 4 work streams which are supported by nationally agreed driver diagrams are:

The hospital continues to link in with SPSP MH colleagues.

In 2020 it was also agreed that the Prevention and Management of Violence & Aggression (PMVA) policies should be reviewed and monitored through the Patient Safety Group as these come under the banner of least restrictive practice. This was added to the role and remit of the group.

2 Current Resource Commitment

Since March 2020 due to covid-19, all SPSP assurance work and walkrounds have been suspended.

National reporting has also ceased at Healthcare Improvement Scotland (HIS) request.

There is currently a vacancy for the Programme Manager for TSH SPSP. This is currently going through the hospital recruitment process.

Group Membership
The membership of the SPSP Steering Group is:

- Director of Nursing and Allied Health Professions (SPSP- MH Executive Lead)
- Professional Nurse Advisor
- Clinical Effectiveness Team Leader

- Consultant Forensic Psychiatrist
- Person Centred Improvement Lead
- Lead Nurse
- Senior Charge Nurse
- Clinical Pharmacist
- Research & Development Manager
- Senior Nurse for Infection Control
- PMVA Senior Trainer

The annual report is presented at the Clinical Governance Group for approval prior to its presentation at the Clinical Governance Committee.

Role of the Group
The role of the group is, wherever possible, to ensure the avoidance of unintended or unexpected harm to people during the provision of health care within The State Hospital.

Aims and Objectives
These include:

- Integrate the Scottish Patient Safety Programme into the daily routine of all State Hospital staff.
- Reduce variation in our clinical practices by using evidence based practice as a means of reducing errors.
- Create an environment of continuous improvement in all areas of healthcare.
- Create an environment where we will share patient safety lessons.
- Contributing to the delivery of patient-centred care.
- Empower staff to develop solutions to improve patient safety.
- Develop innovative approaches to data utilisation to support delivery of high quality patient care and minimise risk of harm.

3 Summary of Core Activity for the last 12 months

Meeting Frequency and Dates Met
The Group has met on 4 occasions over the 12 month period; September 2020, February 2021, April 2021 and June 2021.

Workstream 1 – Communication

Work has commenced to populate the safe essentials of care safe communication driver diagram showing what we are currently doing within the hospital (appendix 1). This will also be used to explore some areas with a view to further improvement. To date areas that will be explored are the documentation for the discharge phase of the patient's pathway, extending the use SBAR formats to other areas in the hospital and reviewing safety briefs to see if any further improvements could be made.

Workstream 2 - Leadership & Culture

Patient Safety Walkrounds
Due to restrictions experienced by the covid-19 pandemic, no leadership walkrounds took place. The Patient Safety Group have however been considering the best way forward with this type of walkround to best ensure engagement between walkround participants, staff and patients, and what the focus of these walkrounds could be. It is anticipated that these will recommence in October 2021.

The safe essentials of care, leadership, and culture driver diagram has been considered at the group. Whilst we have many areas where we can evidence good practice with regards to psychological safety, staff wellbeing and systems for learning there are a few areas that could be explored with a view to further improvements. These include adding more context to data to allow the sharing of good practice easier and exploring what we mean at the hospital by compassionate leadership.

Workstream 3 – Physical Health

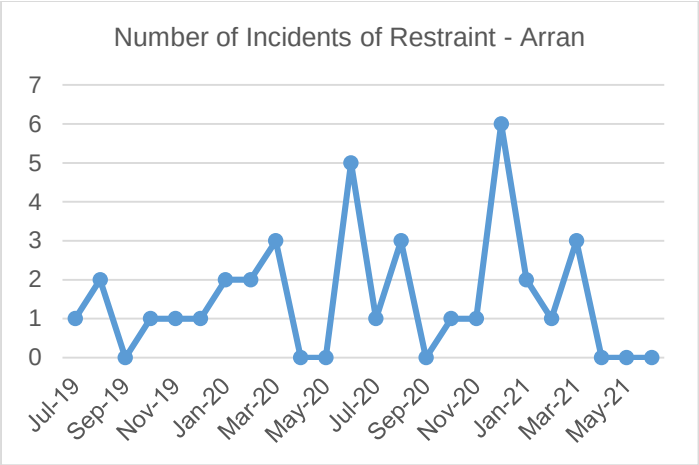
Patients physical health, along with their mental health was one of the main concerns during the restrictions imposed through Covid-19. This has been monitored through the hospital's KPIs and Operating Model Monitoring Group.

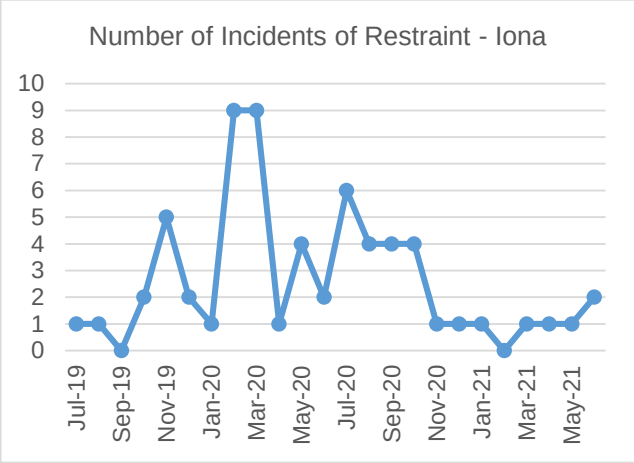
Workstream 4 – Least Restrictive Practice

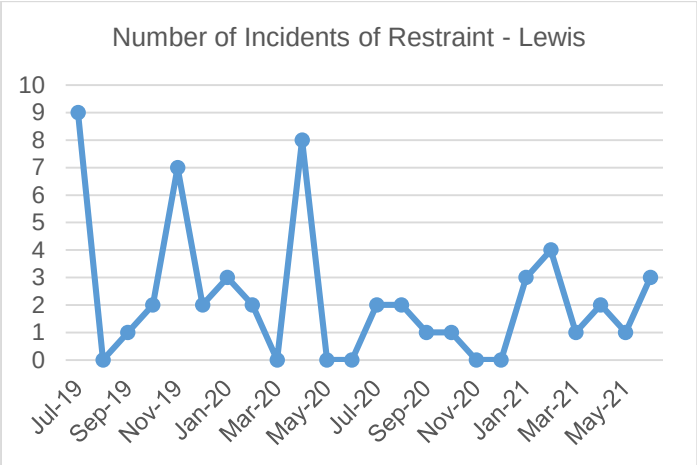
Improving Observation Practice

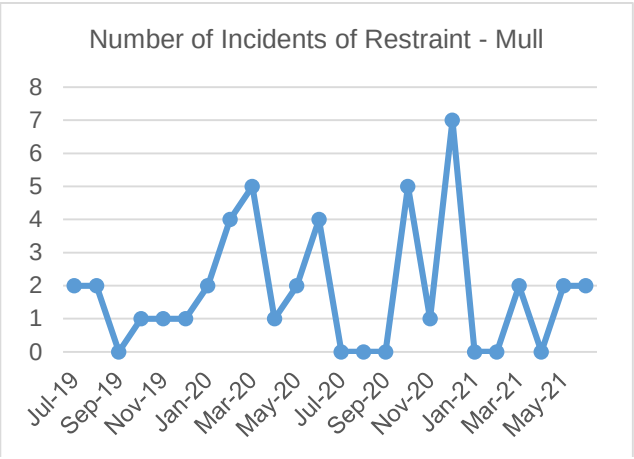
Draft policy was developed and consulted on, with this based on the national policy guidance published by Healthcare Improvement Scotland. Work on policy implementation and associated practice development was paused in March 2020 due to Covid-19. This piece of work restarted in September 2020 and is currently having some enhancements to ensure seclusion level 2 is also included within this policy.

Incidents requiring the use of secure holds are noted in the graphs below (nb different scales). This continues to be small numbers.









Clinical Pause

Fully embedded into current practice and has been utilised in all wards throughout the hospital.

4 Comparison with Last Year's Planned QA/QI Activity

Next 12 months work from last report	Update	Status
Reinstate SPSP group meetings	The meetings were re-instated in September 2020	Complete
Increase collaboration with Nursing Practice Development, with them taking	Practice Development is leading on the review of the Clinical	Ongoing

Next 12 months work from last report	Update	Status
a lead role for improving observation practice.	Engagement Policy with desktop exercises being arranged over the next 2 months	
Refresh the focus of leadership walkrounds and reporting	Discussions continue at the Group to improve the current leadership walkround format to ensure they fit with what hospital staff would like to see from them	Ongoing
Development of Tableau to incorporate patient safety data	The incidents dashboard is operational with further enhancements being made to a patient specific incident dashboard.	Partially complete
Assume responsibility for PMVA suite of policies, monitoring and improvement	The Group assumed responsibility of all the PMVA Policies and are actively taking forward the improvement plans from the audits and the policy reviews	Completed

5 Performance against Key Performance Indicators

Not applicable at this point in time.

6 Quality Assurance Activity

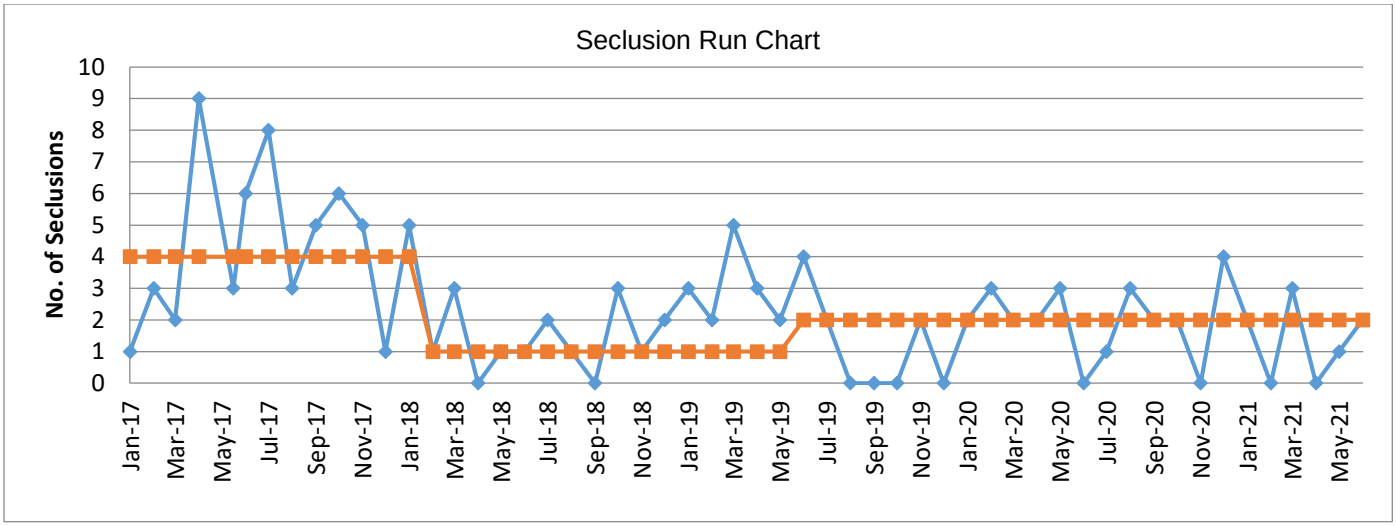
We have 2 main sources of quality assurance. One through the national dataset and the other through the PMVA Policy Governance.

National Dataset

MHO1	Rate of incidents of physical violence and aggression per 1,000 occupied bed days
MHO1db	Days between incidents of physical violence and aggression
MHO2	Rate of incidents of restraint per 1,000 occupied bed days
MHO2db	Days between incidents of restraint
	Average length of incidents of restraint
MHO3	Rate of episodes of seclusion per 1,000 occupied bed days
MHO3db	Days between episodes of seclusion
	Average length of episodes of seclusion
MHO4A	Rate of incidents of self-harm per 1,000 occupied bed days
MHO4Adb	Days between incidents of self-harm
MHO5	Rate of episodes of continuous intervention per 1,000 occupied bed days

Below are examples of the assurance data that is collected. During Covid this data has not been sent to the national team, although the hospital has continued to monitor for assurance and improvement purposes. The data is also discussed at the Patient Safety Group with a view to seeing any trends, shifts or astronomical points that need addressed.

All the national charts during 2020/21 have shown random variation.


Seclusion Run Chart
No. of Seclusions
0
1
2
3
4
5
6
7
8
9
10
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
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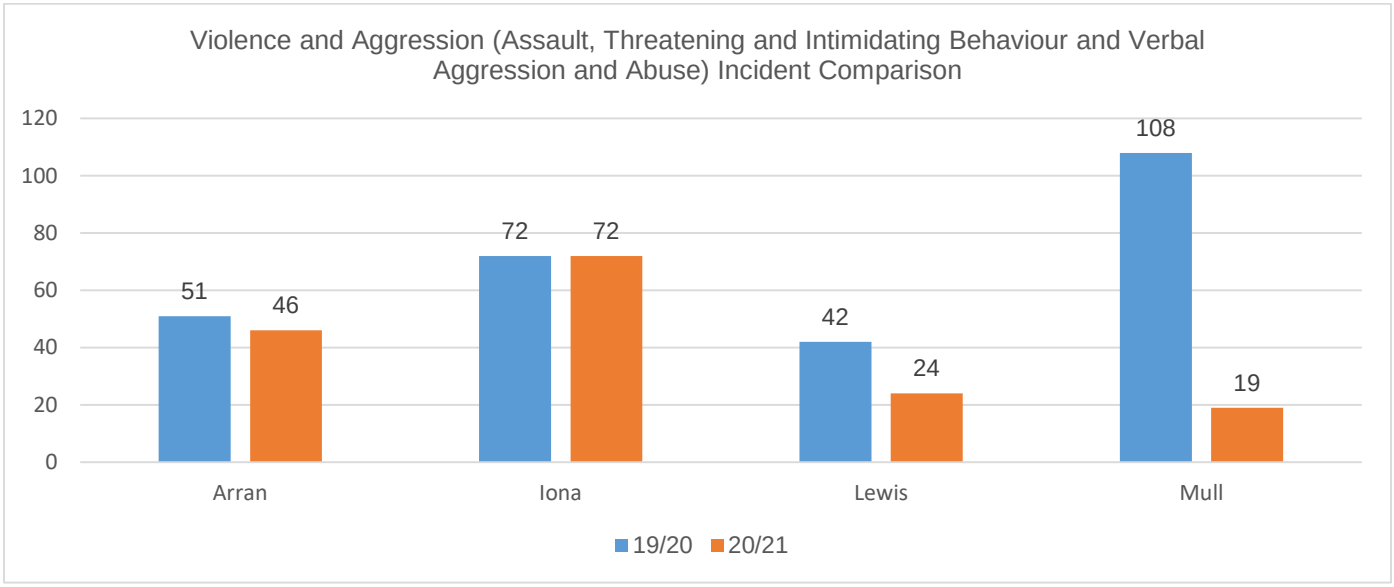
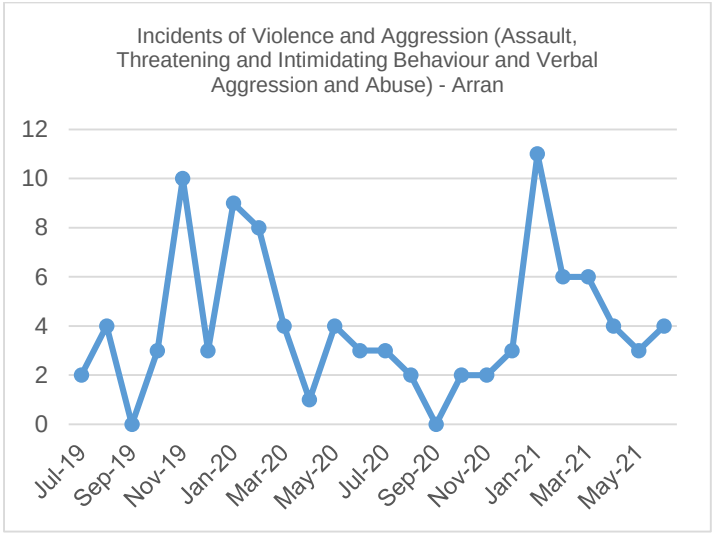
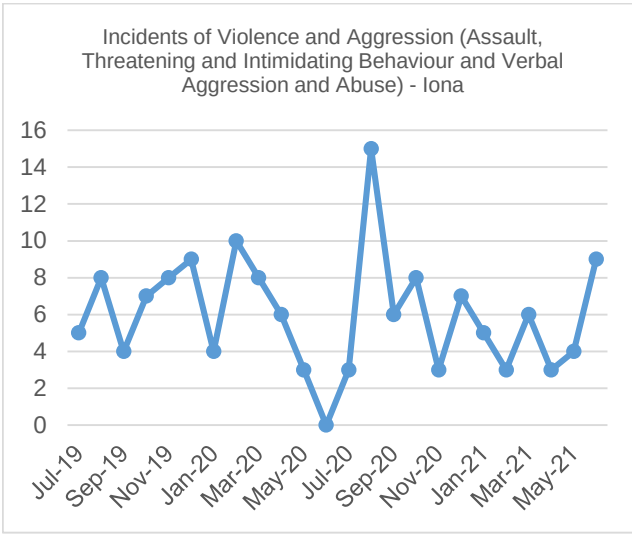
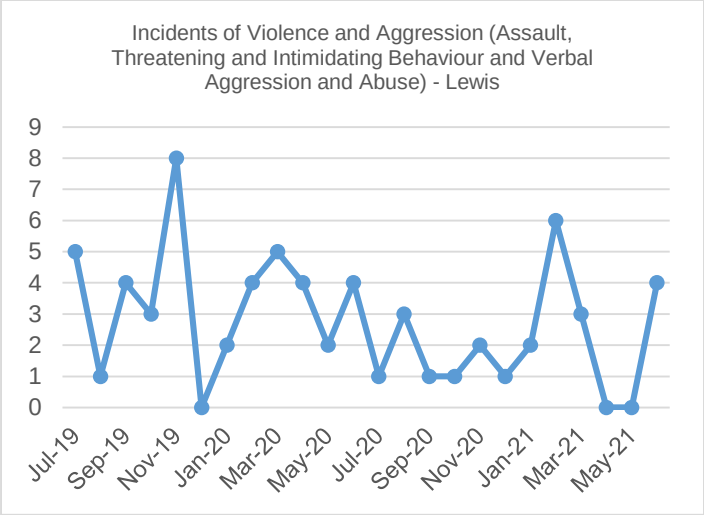
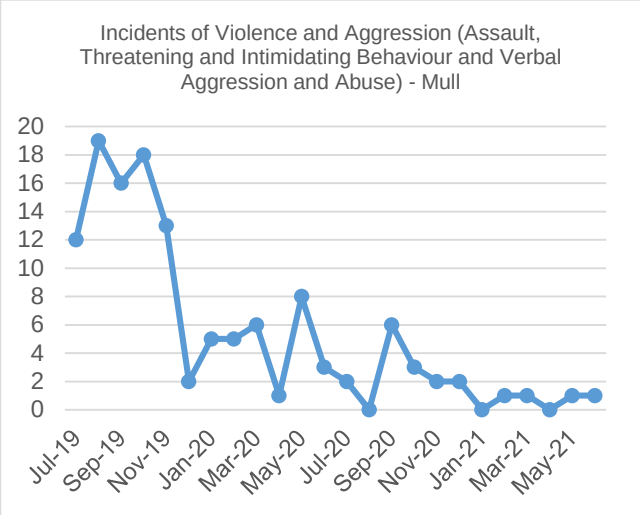

Violence and Aggression (Assault, Threatening and Intimidating Behaviour and Verbal Aggression and Abuse) Incident Comparison
120
100
80
60
40
20
0
51
46
72
72
42
24
108
19
Arran
Iona
Lewis
Mull
19/20
20/21


Incidents of Violence and Aggression (Assault, Threatening and Intimidating Behaviour and Verbal Aggression and Abuse) - Arran
12
10
8
6
4
2
0
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Mar-21
May-21


Incidents of Violence and Aggression (Assault, Threatening and Intimidating Behaviour and Verbal Aggression and Abuse) - Iona
16
14
12
10
8
6
4
2
0
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Mar-21
May-21





*Improvement in the data in Lewis and Mull was predominantly due to 3 patients (1 from Lewis and 2 from Mull no longer being at TSH)

PMVA Policies and Reviews

Below is a table that shows where the PMVA polices are on the review cycle. Currently there are 6 policies, with 2 of these currently past their review date. The table below gives an updates for the ones nearing and past their review dates:

Policy Name	Implemented	Review By	Comments
Physical Intervention Policy	09/05/2018	09/05/2021	For submission to June Policy Approval Group meeting.
Forensic Psychiatric Observation Policy	29/11/2018	22/06/2021	Policy remains under development, with programme of engagement with clinical teams being worked through. Projected implementation date of October 2021.
Seclusion Policy	01/07/2017	31/07/2021	Currently under review.
Use of Extra-ordinary Personal Protective Equipment Policy	24/01/2014	30/10/2021	Proposals for use of enhanced PPE being considered and engagement events are under way. Paper to return to CMT in August 2021, setting out final proposals.
Mechanical Restraint Policy	02/10/2020	02/10/2023	
Policy for the use of Strong Clothing/Strong Bedding	22/01/2021	21/01/2024	

PMVA Policy Governance

2020 saw the review and audit processes in relation to the PMVA policies being handed over to the Patient Safety Group. Aa audit schedule for the audits was agreed as follows:

PMVA Policies	Audit Cycle
Forensic Psychiatric Observation Policy	Audited quarterly (only minimal dataset whilst waiting for new IOP policy to be implemented)
Disassociation Policy	Audited within CPA audit – 2 year cycle
Physical Intervention Policy	Audited bimonthly
Medication in the Management of Violence Policy	Annually through the PRN audit
Seclusion Policy	Annual case studies as numbers very low
Mechanical Restraint System Policy	Audit tool to be agreed following policy review
Use of Extra-ordinary Personal Protective Equipment Policy	Audit tool to be agreed following policy review
Strong Clothing/Strong Bedding Protocol	Audit tool to be agreed
Initial Admission Risk Assessment	Audit under review

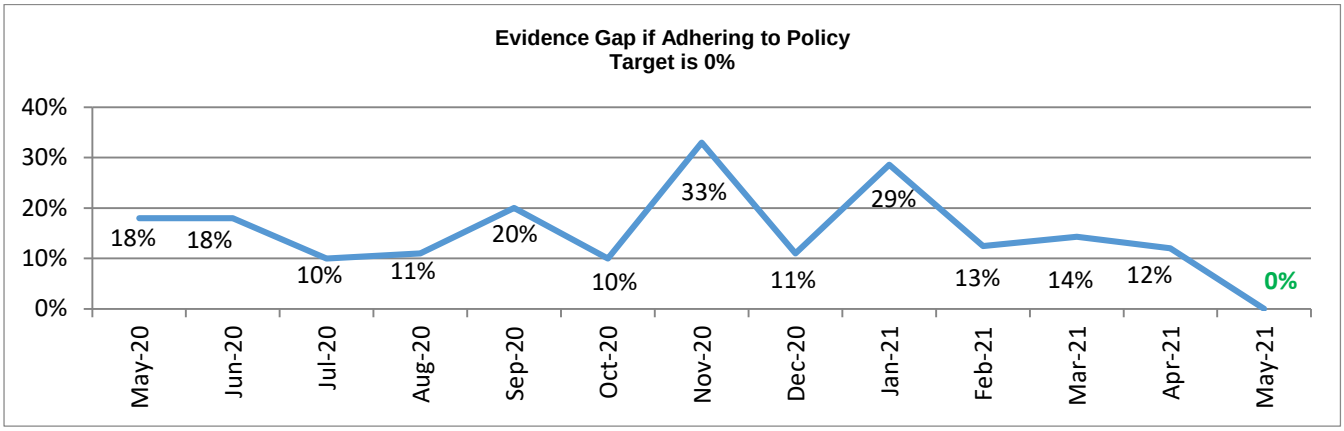
Audit Findings from PMVA Policies

Forensic Psychiatric Observation Policy

The audit findings have shown some good improvements over the last year, with some areas for further improvement still required. The main findings include:

Areas showing improvement:

- For the 27 patients that were placed on Level 2 Observations, there was an increase of evidence found to support observation review discussions taking place within Nursing progress notes using the note type from 69% to 81% of occasions. This in turn reduced the negative gap in supporting evidence by 19% from 58% to 23%.
- Although there is no current requirement within the policy for recording of review discussions within medical progress notes for patients on level 2 observations, it should be noted that evidence of discussions was found for 41% of patients which has continued to increase from 35% and 33% in previous audits.
- For the 9 patients on level 3 observations, 100% of patients had evidence found within the note types of review discussions taking place. This is the first time in the history of this audit and has shown a continued improvement over the past 3 audit periods from 88% and 86%.



- For the 9 patients on level 3 observations Nursing progress notes were reviewed to find evidence that observation level review discussions had taken place between nursing and medical staff. Evidence was found on 89% of occasions, this is an improvement from 50% in the previous audit period. This shows a reduction in the negative gap in data to 11%, this is a decrease in gap from 38% in the previous audit.

Areas for further improvement include:

- There were 4 (15%) patients on Level 2 increased observation levels where evidence could not be found of observation level review discussions having taken place.
- For patients on level 3 observations reviewing only the Medical progress notes where the required note type was used, evidence could be found for 56% of patients that discussions were being held to review those levels. It should be noted that this is a continued improvement from 50% and 14% in previous audit periods.
- For the 7 patients who had been on Level 3 observations for longer than 28 days, 5 (71%) had a minimum of 1 Appendix 4 form available within RiO. From an expected submission of 25 Appendix 4 forms, 19 (76%) were available within RiO. This is a reduction in availability from 80% in the previous audit period.
- Of the 169 occasions where Nursing used the observation review note type, 54% of its use was to record discussions which included the RMO.
- The Clinical Team Meeting Form was left blank regarding observation discussions on 26 (18%) occasions

Posters were introduced during 2020 to show a quick visual to ward staff what was improving and what was still requiring further improvement (appendix 2). These have been welcomed by the wards and further improvements have been shown since their implementation.

Physical Intervention Policy

The main findings from the most recent audit in May this year included:

Areas Showing Improvement:

- On 7 (87%) occasions there were Post Physical Intervention Assessment (PPIA) forms completed by Senior Clinical Cover on RiO. Of the 7 completed PPIA forms all (100%) had been closed off in RiO
- For the 8 occasions on Datix where physical interventions took place there were 2 (25%) occasions where injuries were recorded, both (100%) of which had a corresponding PPIA form completed.

Areas for Improvement:

- Of the 7 PPIA forms completed, the incident time on the PPIA form matched with the incident time recorded in Datix on 2 (29%) occasions.
- For the 2 occasions where injuries were recorded in Datix and the corresponding PPIA form, the information matched on no (0%) occasions.
- Of the 8 occasions where a patient had been taken to the floor and observations should have been recorded within the NEWS, there was 1 (12%) completed NEWS available within RiO.
- There were 7 (87%) occasions following physical intervention where a PRN was administered, 5 (71%) of these were recorded on Medication Forms within RiO.

The group will discuss the ongoing issue with the NEWS at their meetings in the coming months as this is an area that continues to cause concern.

Medication in the Management of Violence

The findings from the 2021 audit included:

Areas of Good Practice:

- All oral and IM does of the same medication were written separately on the prescription sheet.
- Although a large proportion of patients in TSH are routinely written up for as required medication, they are not routinely administered as required (or PRN) medication.

Areas for Improvement:

- There were 57 occasions out of 206 (27.7%) where no reason was put on the administration Kardex as to why the medication had been given.
- On the 4 occasions where patients were administered IM medication, there was no evidence of oral treatment being offered prior to administration. On 2 occasions on Arran these were noted on the PRN Psychotropic Form on RiO where the response and observation monitoring section was completed but no NEWS form was attached to the RiO form or filed in the clinical documentation section of RiO. On the 2 occasions on Lewis where IM PRN was administered there was no evidence that oral medication was offered in the first instance and on both occasions the PRN Psychotropic Medication form was not completed on RiO but the incidents where noted in the progress notes on RIO.

These findings will be discussed and an improvement plan agreed at the Medicines Committee.

Seclusion Policy

Two case studies were performed through 2020. Neither of these showed any concerns with regards to staff following the policy, although on both occasions no evidence of debrief could be found within the patients notes. A piece of work looking at debriefs has been commissioned through the Patient Safety Group with the Head of the Person Centre Improvement Team taking forward patient debriefs and Practice Development taking forward staff debriefs.

7 Quality Improvement Activity

During 2020 the safe essentials of care driver diagrams were published for:

- Leadership and culture
- Safe communications
- Safe clinical and care processes
- Person centred care

The driver diagrams were discussed and populated at June's Patient Safety Group with a view to populating an improvement plan for 2021/22 with any gaps or further improvements the Group would like to explore going forward. A copy of the populated diagrams can be seen in appendix 1.

8 Stakeholder Experience

No stakeholder survey's or questionnaires were carried out throughout the year.

9 Planned Quality Assurance/Quality Improvement for the next year

These will include:

- Populating a plan of work based on the safe essentials of care driver diagrams
- Exploring what the leadership walkrounds should look like in their new format and commence these
- Ensuring the PMVA policies are reviewed and audited, with improvement plans agreed and implemented as required
- Exploring the refreshed Scottish Safety Climate Tools for staff and patients to ascertain if the patient one can be adapted for our patients.

10 Issues

Limited dedicated time to SPSP MH work, which limits ability to progress priorities. This will hopefully be addressed through the recruitment of a part time project manager

Current vacancy of 0.2 WTE administration/data collection.

There is a need to reinstate planned work post COVID-19, and to reintroduce activities such as patient safety walkrounds in a way that balances the need for in person engagement with managing risk of viral transmission.

11 Next review date

The next review date will be August 2022.

Essentials of Safe Care

Leadership and culture: secondary drivers and change ideas

Appendix 1

Aim	Drivers	Change Ideas	What TSH Currently Does
Leadership to promote a **culture** of safety at all levels	Psychological safety	Compassionate leadership at all levels	Care and compassion are part of the core values of TSH. Leadership & management development programmes place emphasis on the interactional and relational aspects of leadership (e.g. servant & authentic leadership). The importance of compassionate leadership is also promoted/supported through other development initiatives (e.g. 'Dare to Lead' book group, Core Strengths SDI initiative). Family-friendly policies and focus on work-life balance. Excellence in Care will introduce SDi to SCNs and Charge Nurses – TSH was going to be a pilot – improvements could still be made in this area. Lots of tools, but concerns over 'compassionate leadership' – this should be explored further to agree what is adding value.
		Collective leadership approach	
		Structured 1:1 time	
		Visible supportive leadership	Strong focus on quality improvement & engagement of staff at all levels of the organization. New management structures & associated multi-disciplinary representation on hospital groups and committees. Multi-disciplinary team working ethos and practices within the hubs. Regular team business meetings across all teams/departments – which include a focus on performance, improvement, learning form mistakes, Clinical pause initiative. Access to AFFINA team development support.
	Staff wellbeing	iMatter – listening to the workforce and identifying improvements	PDPR process (including training for managers on how to have meaningful 1-1 conversations). Access to coaching and other development support (e.g. 360 assessment, Myres-Briggs, SDI). Access to clinical supervision.
		National health and well-being outcomes 1, 8, 9	SCNs in all wards and co-located with their ward teams. Leadership walkrounds. Professional groups & committees (e.g. NAHPAC, MAC). New TSH seminar series. Staff consultation and engagement events. Activities/events to show appreciate for staffs' efforts (e.g. recent distribution of care packages & afternoon teas as part of the national Mental Health Nurses Day).
		Celebrate success	Participation in the annual iMatter survey and Heads of Services agreeing action plans with their teams.
			Annual Health Working Lives programme. TSH Wellbeing Centre and associated events and initiatives. TSH 3030 initiative. iMatter and other staff wellbeing surveys. HR & Wellbeing Group. Staff access to the gym. Onsite occupational health service. Healthy Living Plus award in staff restaurant.
	System for learning	System for identifying the bright spots	TSH Excellence awards. TSH long-service awards. TSH3030 awards ceremony. Articles in VISION. Nominating staff/projects for national awards (e.g. RCP award). Distribution of 'gratitude' lapel badges.
		Measurement system that enables learning	We record areas of good practice within Audit projects but we should explore how to identify bright spots in QI projects
		Processes in place that support the appropriate use of evidence	We are trying to add more context to our data to allow teams to learn, improve, share and spread good practice
			Clinical Effectiveness lead on the gap analysis exercises in the hospital to ensure that evidence if put into practice where appropriate

Essentials of Safe Care

Person centred care: secondary drivers and change ideas

Aim	Drivers	Change Ideas	What TSH Currently Does
Person centred systems and behaviours are embedded and support safety for everyone	Structures and processes that enable safe, person centred care	Person centred/flexible visiting	We offer flexible visits and have started having visits in the Family Centre to make it a nicer environment for all visits. If relatives wish to speak to a member of the Clinical Team this will be facilitated for the team member to attend the Family Centre.
		Person centred care planning documentation	All of our patients have an annual and intermediate case review with the patient at the centre of all discussions. Further improvements are currently being made to this process through the MHPSG.
	Inclusion and involvement	Routinely gather feedback near real- time	All feedback is entered onto a database by a member of the Person Centred Improvement (PCI) Team. This data is then fed through the OMMG fortnightly, the PCI Steering Group and the Clinical Governance Group and Committee, as well as the Board. The practice of sharing feedback requires to be more consistent across the site to allow trends and themes to be highlighted
		Personalise care and support	All patients have personalised care plans for their mental and physical wellbeing. Further improvements are being considered to these through the CPA review work by the MHPSG
	Workforce capacity and capability	Build workforce capabilities in personalising care and support	Practice Development work closely with clinical staff to support the clinical supervision, reflective practice and mentoring models within the hospital.
		Build workforce capabilities in inclusion and involvement	The PCI Lead for the hospital delivers equality and diversity training for all staff and we have an e-learning module for staff to complete. All clinical policies also have an EQIA completed to ensure the protected characteristic groups are considered.
		Create capacity for a person centred reflective workforce	Practice Development and Psychology provide support with regards to reflective practice to staff within the hospital.

Essentials of Safe Care

Safe communications: secondary drivers and change ideas

Aim	Drivers	Change Ideas	What TSH Currently Does
Safe communications within and between teams	Skills: appropriate language, format and content	Staff education and awareness	This area will be explored further with the Learning and Development Centre. Although we have a plethora of e-learning modules and robust induction training the Patient Safety Group will explore the appropriateness of the language, format and content.
	Practice: use of standardised tools for communication	Key Information Summary	All professions that contribute to the CPA review have a summary section within their report that can be easily accessed through RiO and the patient's CPA document
		Immediate Discharge Letter	We have a full discharge pathway within the hospital that is monitored via the discharge variance analysis tool – it is acknowledged that there are still further improvements that could be made to this process to ensure that all information required by the receiving provider on discharge is compiled and sent in a timely manner.
		Structured Communication (SBAR)	This way of working is used for hospital meetings, but not really used within the every-day ward setting. There could be advantages of introducing it for some specific tasks e.g. when phoning NHS 24 out of hours (this can be explored at the Patient Safety Group). SBAR would need a guidance sheet/education as it could me months between staff having to complete one.
	Critical Situations: management of communication in different situations	Safety Brief	During critical situations we have gold and silver command that would be enacted. There are various briefing methods used for these.
		Huddles	We have a Friday afternoon huddle when the weekday staff hand over to the weekend staff ensure all clinical, security and environmental issues are handed over. We also have an 8.30am huddle each morning. From a wider perspective, to avoid critical situations we have 9am MDT meetings (that is classed as our safety brief) that have commenced on one hub (Arran) with roll out being discussed – making sure consistent matters are discussed at these prior to roll out. Ward handovers and contingency meetings also take place. Safety briefs could be explored to highlight any ongoing issue on that ward in relation to environment, ward working etc (Chelsea has examples) that would be held in the office for all visitors to read on entry. Family Centre Visits will be for patients from various wards that may bring some issues that need addressed (centralised visiting)

Essentials of Safe Care

Safe clinical and care processes: secondary drivers and change ideas

Aim	Drivers	Change Ideas	What TSH Currently Does
Safe consistent clinical and care processes across health and social care settings	Reliable implementation of Standard Infection Prevention and Control Precautions (SICPS)	Staff education and awareness	We have various online modules that staff have to complete annually and our Senior Infection Control Nurse also does various education/awareness raising sessions for staff and patients.
		Access to evidenced based guidance and policy	All the Infection Control Operational Guidance/Policies, based on the National Infection Control Manual. Local Policies developed based on NHS Lanarkshire policies
		Safety Leadership Walkrounds	These have been ongoing for a number of years now with a Senior Manager and Non Executive Director as part of the team. This format is currently being reviewed through the Patient Safety Group with a view to improving the questions being asked.
		Access to resources	
	Safe Staffing	Staff education and awareness	There are lots of training courses available within the hospital and also numerous e-learning modules for staff
		Effective rostering	Training delivered by national workforce team and improvements identified by senior nursing staff that will be taken forward. We are also doing work around the predictive absence allowance.
		Real-time staff risk assessment	Meet every morning Mon-Fri to discuss staffing levels and patient dependency for next 48-72 hours and staffing is then monitored by nursing resource throughout the day. Explore the resources currently used for this to ensure best value/added value of this.
		Safety huddles	The 8.30am meeting is our safety huddle Lead Nurse walk rounds take place weekly
		Mitigation	Mitigation would be covered at the 8.30am huddle and reviewed throughout the day depending on patient need. A further huddle takes place where appropriate to look at other contingencies
		Escalation	There is an escalation process in place when there is a risk of safe staffing not being achieved Creating SCN dashboards that will have a focus on workforce and professional issues. EiC will also be using the CAIRE dashboards.

Appendix 2

The State Hospital
PMVA Forensic Psychiatric Observations Policy Adherence

LEVEL 2 OBSERVATIONS

"Close Observations (Level 2) will be reviewed weekly, at a minimum … This should be documented in … the Nursing – Observation Review note type."

LEVEL 2- AREAS OF ACHIEVEMENT

- 81% of patients on level 2 observations had evidence of obs review discussions recorded under the Nursing Obs Review note type (improvement from 69%)

LEVEL 2 - AREAS FOR IMPROVEMENT

- There were 4 (15%) patients on level 2 observation where evidence could not be found of obs level review discussions having taken place.

Ward	No of Patients on Level 2 Increased Obs	No. of Patients where Evidence was recorded using Nursing Observation Review Note Type of Discussions Taking Place	
Arran 1	3	3	100%
Arran 2	3	3	100%
Iona 1	5	5	100%
Iona 2	3	3	100%
Iona 3	1	1	100%
Lewis 1	5	4	80%
Lewis 2	1	1	100%
Lewis 3	1	1	100%
Mull 1	1	1	100%
Mull 2	4	1	25%

Congratulations to 8 wards for achieving best practice

LEVEL 3 OBSERVATIONS

"Constant Observations (Level 3) should be reviewed every day for the first 7 days … A note of these reviews should be made in … Medical Observation Review note type… Where Constant Observations (Level 3) have been maintained for seven days, they should … be reviewed by the RMO/duty RMO … twice weekly. .. with a note of the review being made in RiO in the Medical – Observation Review note type and a review once weekly by the Clinical Team … within the RiO Nursing - Observation Review note type."

LEVEL 3 - AREAS OF ACHIEVEMENT

- 100% of patients on Level 3 observations had evidence of obs review discussions over both Nursing and Medical note types (improvement from 88%)
- 89% of patients on Level 3 observations had evidence of obs review discussions in Nursing note types (improvement from 50%)

LEVEL 3 - AREAS FOR IMPROVEMENT

- 56% of patients on Level 3 observations had evidence of obs review discussions in Medical note types (improvement from 50%)

Ward	No of Patients on Level 3 Increased Obs	No Patients where Evidence was recorded using Observation Review Note Type of Discussions Taking Place			
		Medical		Nursing	
Iona 1	1	1	100%	1	100%
Iona 2	5	2	40%	5	100%
Iona 3	1	1	100%	1	100%
Lewis 2	1	1	100%	1	100%
Mull 2	1	0	0%	1	100%

Congratulations to 3 wards for best practice

ADDITIONAL AREAS OF ACHIEVEMENT

- 86% of patients on increased observations had evidence of obs review discussions taking place within the weekly CTM (reduced from 89%)
- 91% of completed Clinical Team Meeting Forms recorded that obs review discussions had taken place

ADDITIONAL AREAS FOR IMPROVEMENT

- Within Nursing, the Obs Review note type was used to record Medical & Nursing review discussions on 54% of occasions. The remaining 46% recorded SCC to CN review discussions
- 76% of Appendix 4 Forms were complete and available within RiO (improved from 72%)
- 2 patients had no Appendix 4 Forms completed and available within RiO
- The Observation Review Field within the CTM Form was left blank on 18% of occasions

Figures correct as at May 2021 audit period