THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE

Agenda Reference:	Item 11
Date of Meeting:	11 August 2022
Presented by:	Director of Nursing and Allied Health Professions
Title of Report:	Scottish Patient Safety Programme Report July 2021 – June 2022

Table of Contents

1 Core Purpose of Programme

2 Current Resource Commitment

3 Summary of Core Activity for the last 12 months

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

5 Performance against Key Performance Indicators

6 Quality Assurance Activity

7 Quality Improvement Activity

8 Stakeholder Experience

9 Planned Quality Assurance/Quality Improvement for the next year

10 Next review date

References

1 Core Purpose of Programme

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 (TSH) 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 four work streams which are supported by nationally agreed driver diagrams are:

2 Current Resource Commitment

National reporting has remained ceased at Healthcare Improvement Scotland's (HIS) request.

TSH successfully recruited a part-time Project Manager for the SPSP programme in August 2021. This role equating to 1 day per week has been extended for another year.

Group Membership

The membership of the local Patient Safety Group is:

- Director of Nursing and Allied Health Professions (SPSP- MH Executive Lead)
- SPSP-MH Project Manager
- Head of Clinical Quality
- Consultant Forensic Psychiatrist
- Person Centred Improvement Lead
- Professional Nurse Advisor

- Lead Nurse
- Senior Charge Nurse
- Clinical Pharmacist
- Research & Development Manager
- Senior Nurse for Infection Control
- PMVA Senior Trainer
- Head of Risk and Resilience
- Specialist Occupational Therapist

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 TSH.

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.
- Understand the impact of service delivery for those with lived experiences in the context of patient safety.

3 Summary of Core Activity for the Last 12 months

Meeting Frequency and Dates Met
The Group met on 6 occasions during the 12-month period. This was consistent with planned bi-monthly meetings, which were reinstated in April 2021 following a pause due to the COVID-19 pandemic.

Essentials of Safe Care
The four driver diagrams under this work stream were reviewed by the group and all change ideas were prioritised into categories of high, medium and low. We could evidence areas of good practice within the four primary drivers whereby we felt confident in our current procedures. Three high priority change ideas were included into the group's work plan for 2022; these were providing a system for identifying and spreading best practice; shift handovers and ensuring we were consistent in our leadership approach.

Work Stream 1 – Communication

Learning into Practice (LiP) Meetings:
TSH launched the Learning into Practice (LiP) meetings in September 2021 to provide a system for spreading best practice and facilitate wider learning. This is an internal process to support clinical teams to think about and share learning from their clinical practice and

identify areas for improvement. It is based upon systems thinking and improvement methodologies and supports the local delivery of recommended national approaches to patient safety and staff learning. An initial session highlighting the purpose of the system was facilitated followed by two sessions to date.

Work Stream 2 - Leadership & Culture

Quality and Safety Visits
Due to the restrictions imposed by COVID-19, the previous work stream of Leadership Walkrounds was paused. The local SPS Group reviewed academic literature and benchmarked against other NHS Boards to inform a refresh of TSH approach to conducting clinical area visits with senior level management. A guidance document was created for the new approach to Quality and Safety Visits by incorporating the 15 Steps Methodology, a toolkit developed to explore inpatient mental health areas through the eyes of service users and carers. 3 visits were achieved from their commencement in February 2022. 2 visits were cancelled due to COVID transmission in the wards and a further 2 were cancelled due to staffing pressures across the Hospital; all four will be rescheduled. Any actions or themes arising from these were reported to the local Patient Safety Group on a bi-monthly basis and patient feedback shared within the local 'Learning from Feedback' Report.

Work Stream 3 – Least Restrictive Practice

Improving Observation Practice (IOP)
Work towards implementing TSH new clinical observation and engagement policy has continued to progress slowly since September 2020 due to a number of COVID-19 related restrictions and the redeployment of Nursing Practice Development priorities in order to support wards throughout this time. A draft policy has been created and shared at a number of forums and committees across the Hospital which has been positively received. A revised timeline for implementation of the new policy has been set for January 2023 with the stakeholder engagement scheduled for the Autumn of 2022. TSH were successful in a bid to engage in a collaborative with HIS which will enable additional input from external colleagues delivering the national SPSP-MH agenda which will support the use of a quality improvement approach for the implementation and ongoing review of this policy.

Clinical Pause
The TSH Clinical Pause system is designed to allow team members to 'pause' clinical thinking and activity with a particular patient or situation. This allows the team to come together to reflect on whatever the situation is and then formulate a plan to manage it. This system is now fully embedded into current practice, has been utilised in all wards throughout the Hospital and has been incorporated into the IOP policy.

Work Stream 4 – Physical Health

Patients physical health, along with their mental health was, and still remains, one of the main concerns during the restrictions imposed throughout the Covid-19 pandemic. Patients' physical health continues to be monitored through the Hospital's corporate KPI's, by the Operating Model Monitoring Group (OMMG) and the Physical Health Steering Group (PHSG).

4 Comparison with 2020/21 Planned QA/QI Activity

Table 1: Comparison with 2020/21 Planned QA/QI Activity

Description of work stream	Update	Status
Populating a plan of work based on the essentials of safe care driver diagrams.	All four driver diagrams were discussed and areas of priority were highlighted and included in the annual work plan.	Complete
Increase collaboration with Nursing Practice Development, with them taking a lead role for improving observation practice.	Practice Development is leading on the review of the Clinical Engagement Policy with a draft policy underway and an implementation group being established.	Ongoing
Explore what the leadership walkrounds should look like in their new format and commence these.	New guidance document for Quality and Safety Visits was developed and approved. New process commenced in February 2022.	Complete
Ensure the PMVA policies are reviewed and audited, with improvement plans agreed and implemented as required.	Policies are regularly reviewed and audited with results shared via posters with relevant staff groups.	Ongoing
Explore the refreshed Scottish Patient Safety Climate Tools for staff and patients and ascertain if the patient version can be adapted for our patients.	Person Centred Improvement Lead has consulted with the Patient Partnership Group (PPG) around the tool which has now been adapted for local use in agreement with the national SPSP-MH Team.	Ongoing

5 Performance Against Key Performance Indicators

Due to COVID-19 and the implementation of the Interim Clinical Operations Policy, all local Key Performance Indicators (KPI's) pertinent to Patient Safety were reported via the OMMG during this time. These are:

- Reported incidents relating to patients on level 3 observations
- Patients on level 3 observations within their bedroom
- Patients on level 3 observations out with their bedroom
- Additional staff required for patients on level 3 observations within their bedroom
- Additional staff required for patients on level 3 observations out with their bedroom
- Seclusions
- Patients requiring SRK within the hospital

6 Quality Assurance Activity

We have three main sources of quality assurance; the national dataset, the OMMG and PMVA Policy Governance.

National Dataset

Table 2: National Dataset Indicators

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 at their request, although the Hospital has continued to monitor for assurance and improvement purposes. HIS are reviewing the ask of Boards in relation to restarting a scaled down version of monthly data collection; no decision has been agreed at the time of writing this report.

As can be seen below we continue to see random variation with seclusions with no major areas of concerns within the audits.

Chart 1: Seclusion Data

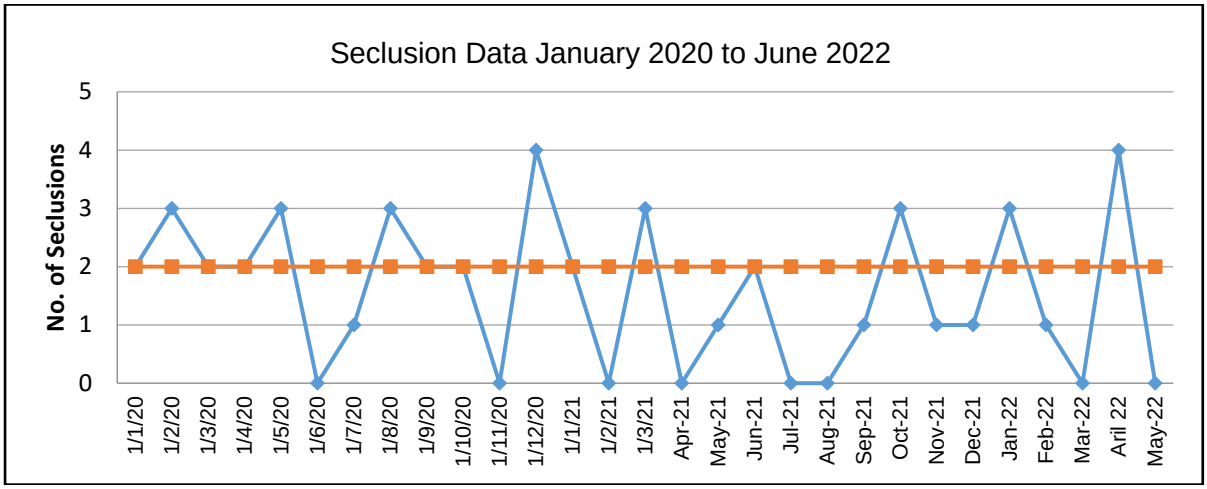
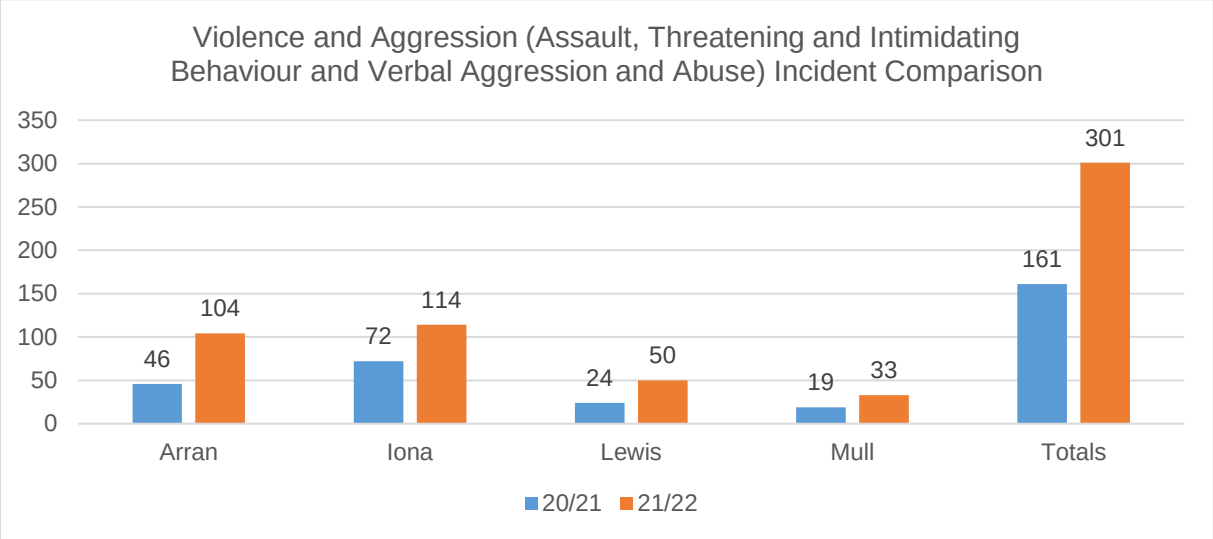
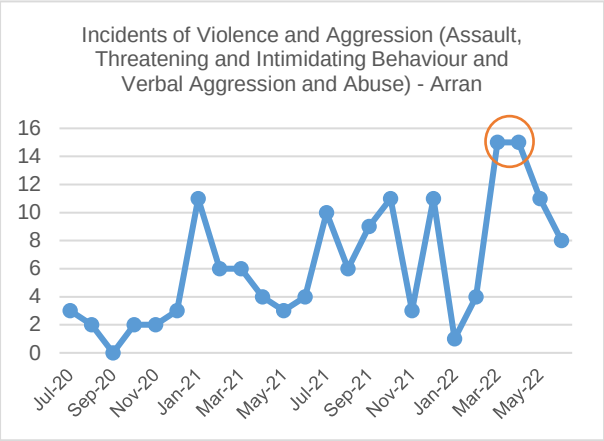


Chart 2: Violence and Aggression Incident Comparison



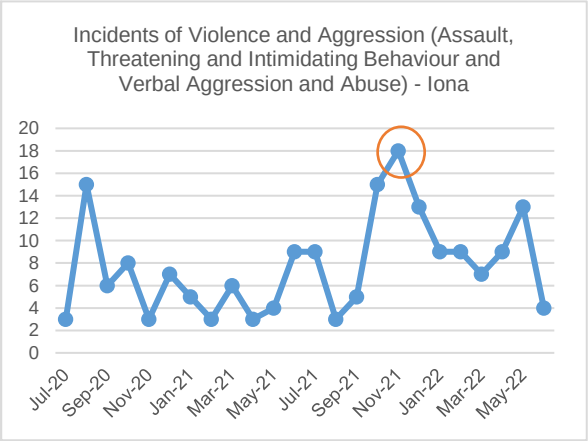
During the reporting period, there was 27 Assaults, 189 instances of Threatening and Intimidating Behaviour and 85 instances of Verbal Aggression and Abuse.

Chart 3: Arran Violence and Aggression Incidents



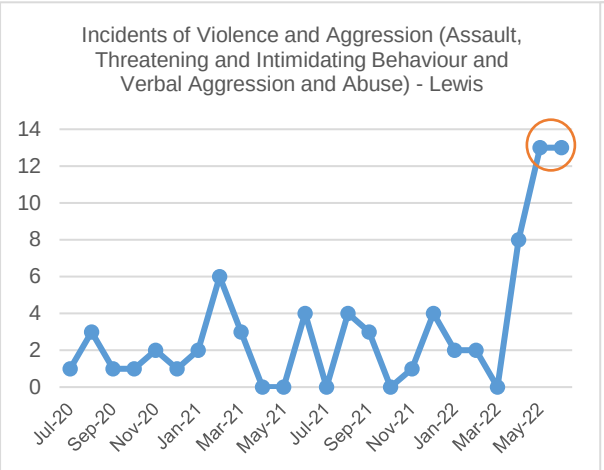
Seven patients contributed to these figures.
One patient responsible for 19 out of the 30 incidents.

Chart 4: Iona Violence and Aggression Incidents



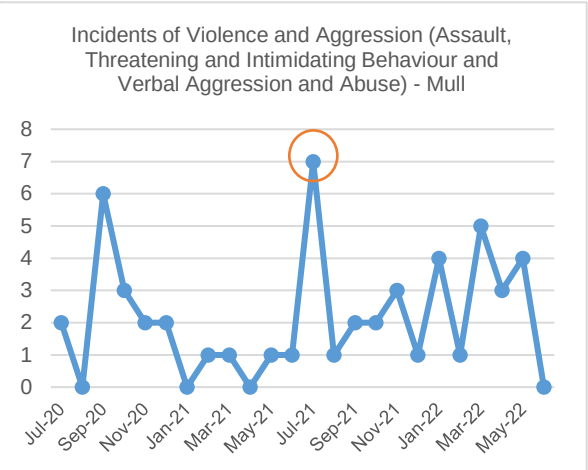
Five patients contributed to this figure.

Chart 5: Lewis Violence and Aggression Incidents



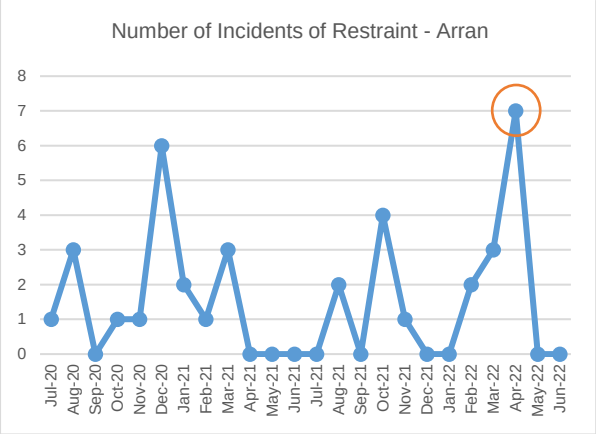
Four patients contributed to this figure.
One patient responsible for 19 out of the 26 incidents.

Chart 6: Mull Violence and Aggression Incidents



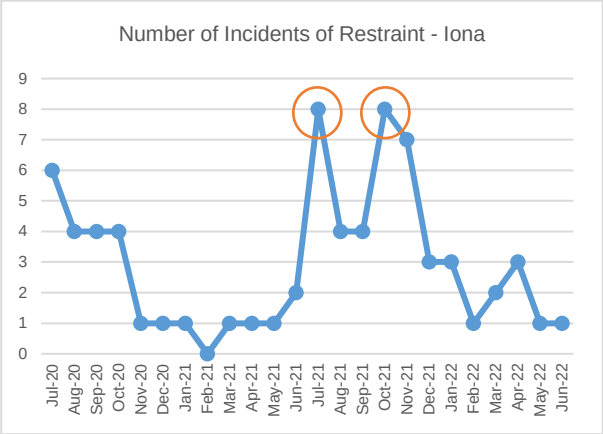
Two patients contributed to this figure.
One patient responsible for 6 out of the 7 incidents.

Chart 7: Arran Restraint Incidents



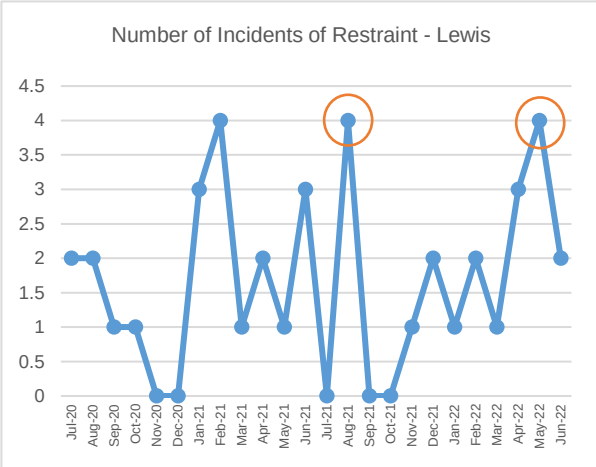
Three patients contributed to this figure.
One patient responsible for 5 out of the 7 incidents.

Chart 8: Iona Restraint Incidents



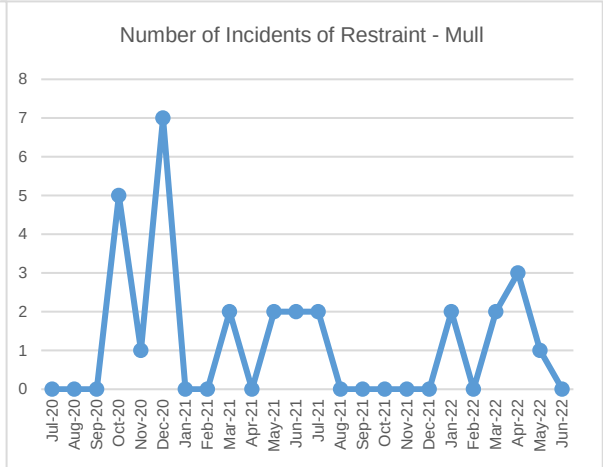
Five patients contributed to July 21's figure.
Four patients contributed to October 21's figure.

Chart 9: Lewis Restraint Incidents



Two patients contributed to August 21's figure.
Four patients contributed to May 22's figure.

Chart 10: Mull Restraint Incidents



PMVA Policies and Reviews

Below is a table that shows where the PMVA policies are on the review cycle.

Table 3: PMVA Policies and their Review Cycle

Policy Name	Implemented	Review By	Comments
Physical Intervention Policy	09/05/2018	31/12/2022	On schedule.
Forensic Psychiatric Observation Policy	29/11/2018	31/12/2022	The current policy on the intranet has been reviewed as fit for purpose with an extension granted to December 2022. This policy will be superseded by the observation to intervention piece of work currently underway.
Seclusion Policy	01/07/2017	31/12/2022	The current policy on the intranet has been reviewed as fit for purpose with an extension granted to December 2022. This policy will be implemented at the same time as the new

Policy Name	Implemented	Review By	Comments
			intervention policy as it includes continuous intervention
Use of Extra-ordinary Personal Protective Equipment Policy	24/01/2014	30/06/2022	This policy is currently being review.
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

An audit schedule for the audits was agreed as follows:

Table 4: PMVA Policy Audit Schedules

PMVA Policies	Audit Cycle
Forensic Psychiatric Observation Policy	Quarterly (only minimal dataset whilst waiting for new IOP policy to be implemented)
Disassociation Policy	Within CPA audit – 2 year cycle
Physical Intervention Policy	Bi-monthly
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 cycle to be agreed following policy review
Use of Extra-ordinary Personal Protective Equipment Policy	Audit cycle to be agreed following policy review
Initial Admission Risk Assessment	Audit cycle under review

Audit Findings from PMVA Policies

PMVA Post Physical Intervention Audit

Areas of Good Practice

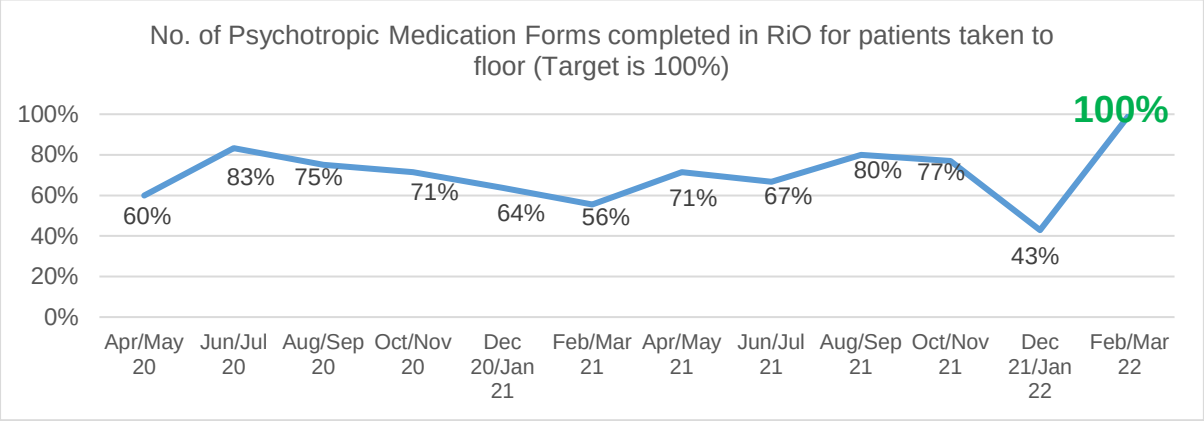
- Of 13 occasions where secure holds were applied, there were Post Physical Intervention Assessment (PPIA) forms completed by Senior Clinical Cover on RiO available for 11 (85%) occasions.
- Of the 11 completed PPIA forms all (100%) had been closed off in RiO
- For the 3 occasions on Datix where injuries were reported, a PPIA form was available for all 3 (100%)

- There were 8 (80%) occasions following physical intervention where a PRN was administered, all (100%) of these were recorded on Psychotropic Medication Forms within RiO.

Areas for improvement:

- Of the 11 PPIA forms completed, the incident time on the PPIA form matched with the incident time recorded in Datix on 6 (55%) occasions.
- For the 3 instances where injuries were recorded on Datix, the information matched with the injury site details recorded on the PPIA form on 1 (33%) occasion
- For the 3 instances where injuries were recorded, entries in the progress notes, Datix and the PPIA forms cross matched on no (0%) occasions.
- Of the 10 occasions where a patient had been taken to the floor and observations should have been recorded within the NEWS, there were 3 (30%) completed NEWS available within RiO.
- It was observed that on one occasion, from the incident time recorded in DATIX it was a further 5 hours and 28 minutes before the relevant progress note was entered.

Chart 11: Number of PRN forms complete on RiO for patients taken to the floor



Observation Level Audit

Areas showing improvement

- For the 22 patients that were placed on Level 2 Observations, 82% of patients had evidence of review discussions taking place. If you excluded General Progress Note type, there would be a gap in supporting evidence of 18%.
- For the 8 patients on level 3 observations, 100% of patients had evidence found within the note types of review discussions taking place.
- For the 8 patients on level 3 observations Medical progress notes were reviewed to find evidence that observation level review discussions had taken place between nursing and medical staff. Evidence was found on 88% of occasions. If you excluded General Progress Note type, there would be a gap in supporting evidence of 12%.
- For the 8 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 88% of occasions. If you excluded General Progress Note type, there would be a negative difference in data of 12%.
- Of 9 RMO's that had patients on increased observation levels there is a requirement for 6 of them to use the note type for level 3 patients. This was carried out by 5 (83%) of the relevant RMO's to varying degrees.
- The observation section of the CTM Form was completed on 65 (87%) occasions.

7 Quality Improvement Activity

During 2021, the essentials of safe care driver diagrams were discussed and populated with the intention of prioritising the numerous change ideas into a focussed number of areas for improvement. A local resource (Appendix 1) to strategically prioritise the change ideas into high, medium and low priority was adapted from that developed for prioritising Equality Outcomes. The systematic prioritisation gained attention from our national colleagues at HIS and members of the Group presented at national webinars and conferences on our progress in this area. This is now a national resource available to all Boards which HIS have allocated within their website resources.

8 Stakeholder Experience

There were two surveys related to restraint in practice that were circulated to relevant staff over the reporting year. The results for these were provided to the Lead Nurses who then disseminated the results to the wider clinical staff.

9 Planned Quality Assurance/Quality Improvement for the Next Year

These will include:

- Renew the suite of local SPS KPI's and begin reporting at every meeting.
- Continue to focus on quality and safety through visits to clinical areas and engagement with Hospital fora.
- Review the essentials of safe care priorities and incorporate the next areas of priority into the annual work plan for 2023.
- Implement 'Improving Observation Practice' Policy and evaluate outcomes.
- Use locally tailored Patient Safety Climate Tool to elicit and act on feedback from patients.

10 Next Review Date

The next review date will be August 2023.

Appendix 1: The State Hospital Prioritisation Tool

Scottish Patient Safety Programme: Essentials of Safe Care – prioritising actions

Aim:

Change idea:

Please apply appropriate ratings to the following indicators:

1.	**Scale**	**Maximum % of target stakeholders affected**				
		10%	**25%**	**50%**	**80%**	**100%**
	Rating	**1**	**2**	**3**	**4**	**5**
2.	**Impact**	**Organisational culture of safe, consistent, person centred care**				
		Prevents	**Limits**	**Supports**	**Promotes**	**Achieves**
	Rating	**1**	**2**	**3**	**4**	**5**
3.	**Improvement**	**To stakeholder experience**				
		None	**Nominal**	**Minimal**	**Significant**	**Maximum**
	Rating	**1**	**2**	**3**	**4**	**5**
4.	**Concern**	**Significance of Issue**				
		None	**Cause for Concern**	**Concern**	**Significant Concern**	**Merits Urgent Action**
	Rating	**1**	**2**	**3**	**4**	**5**
5.	**Risk**	**Of potential negative impact(s) (if outcome not achieved)**				
		Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
	Rating	**1**	**2**	**3**	**4**	**5**

Indicators	**Rating**
1. Scale – number of relevant stakeholders affected	
2. Impact – Organisational culture of safe, consistent, person centred care	
3. Improvement – to stakeholder experience	
4. Concern – significance of issue	
5. Risk – of having a negative impact(s)	
Total Score	