THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE

Date of Meeting:	14 August 2025
Agenda Reference:	Item No: 10
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Associate Director of Nursing
Title of Report:	Patient Safety Programme 12 Month Report
Purpose of Report:	For Noting

1 SITUATION

This annual report is intended to provide the Clinical Governance Committee with a summary update on the work undertaken by the Patient Safety Forum from July 2024 – May 2025.

2 BACKGROUND

The Scottish Patient Safety Programme (SPSP) is a national quality improvement programme that aims to improve safety and reliability of healthcare across NHS Scotland. Since its launch in 2008 the programme has expanded to support improvements in safety across a range of settings including Acute and Primary Care, Mental Health, Maternity, Neonatal, Paediatric Services and medicines safety.

3 ASSESSMENT

In May 2024 there was commitment to review the focus of the SPSPMH (2024 - 2027) Programme to fully understand where the greatest safety issues are within the healthcare system, using the Scottish Approach to Service Design, and reporting through the SPSPMH Expert Reference Group to develop its priorities and change package for the next learning system and collaborative. The programme will collaborate with a range of stakeholders including NHS boards, Scottish Government, national boards, people with lived experience, third sector and professional bodies who will also sit within the SPSP Expert Reference Group. This group has been established to provide advice on the content and direction of the whole programme, including the continuation of successes of the SPSPMH collaborative and a national learning system, in addition to the core mental health standards work.

The State Hospital is represented on the SPSPMH Expert Reference Group by the Associate Director of Nursing with the Lead PMVA Advisor/Senior Nurse (Nursing Practice Development) acting as Deputy and are responsible for ensuring that TSH is aligned and engaging with all relevant national improvement priorities.

4 RECOMMENDATION

The Committee is invited to note the content of the report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Consistent with current policy and objectives. Corporate Objective – "Better Care".
Workforce Implications	There are no workforce implications.
Financial Implications	There are no financial implications.
Route to Committee Which groups were involved in contributing to the paper and recommendations.	Clinical Governance Group.
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks.
Assessment of Impact on Stakeholder Experience	
Equality Impact Assessment	PMVA policies all have completed EQIA.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	All data is across the entire patient population.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick (✓) One: ☑ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Preface

The Scottish Patient Safety Programme (SPSP) is a national quality improvement programme that aims to improve safety and reliability of healthcare across NHS Scotland. Since its launch in 2008 the programme has expanded to support improvements in safety across a range of settings including Acute and Primary Care, Mental Health, Maternity, Neonatal, Paediatric Services and medicines safety.

In May 2024 there was commitment to review the focus of the SPSPMH (2024 - 2027) Programme to fully understand where the greatest safety issues are within the healthcare system, using the Scottish Approach to Service Design, and reporting through the SPSPMH Expert Reference Group to develop its priorities and change package for the next learning system and collaborative. The programme will collaborate with a range of stakeholders including NHS boards, Scottish Government, national boards, people with lived experience, third sector and professional bodies who will also sit within our Expert Reference Group.

The SPSPMH Expert Reference Group has been established to provide advice on the content and direction of the whole of the programme, including the continuation of successes of the SPSPMH collaborative and a national learning system and the core mental health standards work.

The SPSPMH Expert Reference Group has a responsibility to maintain transparency, with excellent communications links with Scottish Government colleagues and programmes of work, other SPSP programmes, other Healthcare Improvement Scotland programmes and functions, Excellence in Care and assurance colleagues as well as relevant national bodies and groups to facilitate open and regular communication.

The State Hospital is represented on the SPSPMH Expert Reference Group by the Associate Director of Nursing with the Lead PMVA Advisor/Senior Nurse (Nursing Practice Development) acting as Deputy.

1 TSH PATIENT SAFETY GROUP

1.1 Group Remit

Members of The State Hospital Patient Safety Group work collectively to ensure that every patient being cared for within hospital experiences high quality, safe, person-centred care at all times with a particular focus on improving observation practice and minimising all harms associated with restraint and seclusion.

1.2 Group Aims and Objectives

- To integrate the Scottish Patient Safety Programme areas of work, where applicable, into daily practice at TSH
- To reduce variation in clinical practice by using evidence-based decision-making processes
- To develop innovative approaches to data collection and utilisation to support the delivery of high-quality patient care and minimise the risk of harm.
- To reduce errors in practice through reviewing data and making subsequent evidence-based decisions thereafter.
- To create and promote learning environments that have a focus on continuous improvement.
- To empower staff to develop sustainable solutions to improve patient safety.
- To create environments where reflecting and learning from events is the “norm”
- To understand the impact of service delivery for those with lived experiences in the context of patient safety.

1.3 Group Membership and Meeting Schedule

The Patient Safety Group meet on a bi-monthly basis and core membership includes:

- Associate Director of Nursing (Chair)
- Head of Clinical Quality
- Consultant Forensic Psychiatrist
- Senior Charge Nurse x 2
- Person Centred Improvement Lead
- Head of Pharmacy
- Senior Nurse for Infection Control
- PMVA Senior Advisor
- Head of Risk and Resilience
- Risk Management Facilitator
- Specialist Occupational Therapist
- Staff Side Representation

The Director of Nursing, AHP and Operations continues as Sponsoring Director for the group, overseeing all areas of business.

The group invite subject matter experts, and commission short-life working groups (SLWGs), as and when necessary.

2 SUMMARY OF CORE ACTIVITY FOR THE LAST 12 MONTHS

The key priorities identified for 2024/2025 were:

1. Evaluate outputs from new Clinical Care policy.
2. Support eradication of Daytime Confinement (DTC).
3. Repeat patient safety survey.
4. Review patient safety data by clinical service area.
5. Reporting of medicines management by clinical service area.

6. Promote psychologically safe working environment through debrief process.
7. Engage with the Quality-of-Care SLWG, and trial the collaboratively developed Quality of Care documentation within TSH.
8. Review data presented in six month and annual Patient Safety reports and consider areas for improvement.

2.1 Evaluate outputs from the new Clinical Care policy

The new Clinical Care policy was implemented on 1st May 2024. Post implementation there have been two policy compliance audits undertaken and a further twelve-month policy review is now underway (N.B: 12-month review was slightly delayed to allow RSM assurance audit to be undertaken first).

Both compliance audits prioritised seven aspects of the new policy for review. These were:

Enhanced Care Plan (ECP)
1. Ensure interventions are being entered by all relevant multi-disciplinary team members
2. Ensure daily reviews are being recorded within RiO as directed
3. Ensure weekly reviews are being recorded within RiO as directed
4. Ensure review at 28 days is being recorded within the ECP as directed
5. Ensure ECPs are being closed off by RMOs as directed

Patient Safety Plan (PSP)
6. Ensure weekly reviews are being recorded within RiO as directed
7. Ensure PSPs are being closed off by NICs as directed

Similar areas of good practice along with areas for improvement were identified across both audits. The areas for improvement included:

- Better completion of ECPs from wider MDT members, particularly in respect the interventions each member of the team will undertake support patient progress back towards General Care.
- RMO and NICs to record daily reviews for the first 7 days within ECPs.
- RMO and NICs to record weekly reviews within both ECPs and PSPs.
- Improved evidence of ECP and PSP reviews at weekly Clinical Team meetings.
- All RMO's (ECPs) and NICs (PSPs) to be aware of their responsibility for closing off forms.
- A clear process should be identified by medical staff to ensure cover arrangements are put in place to support completion of daily reviews over a weekend period.
- MDT members to make themselves aware of the content of the policy and what is required of them.

Following the second audit cycle it was also recommended that quality checks of ECPs are undertaken to ensure all interventions are SMART (specific, measurable, achievable, relevant and time bound).

Summary and Next Steps

- Overall, the Clinical Care policy has been introduced into practice without any significant challenges however it is evident from the audits undertaken to date that there is further work required to support clinical teams fully adopting the principles of least restrictive approach, with all members of the MDT providing regular input to support patients return to General Care following a period of more intensive support (i.e. Enhanced Care).
- Over the coming weeks a review of both the policy content and audit of compliance against the policy will be undertaken. Finding from this will be reported to the October Patient Safety Group and then the Clinical Governance Group thereafter.

2.2 Support eradication of Daytime Confinement (DTC)

Following on from the work of the DTC Short Life Working Group in 2024 there are now several forums that are responsible for ensuring DTC returns to a "never-event" position by October 2025. One such forum is the Patient Safety Group where DTC is a standing agenda item, and any instances of daytime confinement are viewed through a lens of patient harm. Members of the Patient Safety forum review DTC data at each bi-monthly meeting and consider any actions required to support Service Leadership Teams in addressing potential harms from this practice.

A review of the nursing resource data in early 2025 identified that the Transitions Service was consistently working with the lowest core staffing establishment meaning that patients within the service were disproportionately impacted by DTC. To address these issues, whilst also recognising the additional rehabilitative requirements of patients within the Transitions Service, approval was sought from the Corporate Management Team to increase the core nursing establishment within this area.

Summary and Next Steps

- Following the introduction of additional staff the Transitions Service are now experiencing improved resource stability and are better able to fulfil their service functions whilst improving patient experience. Most notably, instances of DTC have largely been eradicated.
- The Nursing Directorate will continue to monitor the impact of the additional staff with findings reported to the Corporate Management Team (CMT).

2.3 Repeat Patient Safety Survey

Between 13 August 2024 and 16 October 2024 all patients in The State Hospital were provided with the opportunity to take part in the "Safely Recovering: Your Experiences in The State Hospital" questionnaire.

The questionnaire consisted of 25 questions which covered themes of safety; care and treatment; access to staff; access to activity; communication and raising concerns; and infection control. There was also the opportunity for patients to provide any additional feedback at the end of the questionnaire. The average number of patients in the hospital during the distribution period was 100 and there were 53 returned questionnaires.

Table 1 (below) details the number of responses received per ward (N.B. 2023's questionnaire was distributed before implementation of the new Clinical Model therefore unable to draw any comparisons for these time points).

Table 1: Returned Survey Responses per Ward

Year	Arran 1	Arran 2	Arran 3	Iona 1	Iona 2	Iona 3	Lewis 1	Lewis 2	Lewis 3	Mull 1	Mull 2	Total
2023	5	4	-*	5	11	9	3	7	5	4	5	58
2024	2	8	3	-*	4	6	9	5	3	4	6	50

NOTE: - * ward not operational therefore no responses possible

In terms of patients' views of what safety meant to them there was a noted theme across both years that this encompassed a sense of being protected from harm, danger or violence and feeling happy, relaxed and comfortable across all environments in the hospital. Most responses received indicated that patients did feel safe during the day and at nighttime across all areas of the hospital. There was a small amount of responses which highlighted that some patients felt unsafe within one ward however these were all attributed to the unpredictable behaviour of a peer.

With regards to access to staff, communication and raising concerns, most patients were able to identify staff members that they could speak with if they had any concerns.

Likewise, most patients felt that staff, in in particular keyworkers, spent enough time with them. In terms of accessing support the majority of patients also answered that they were able to seek out support when required however there were a small number of responses which indicated that patients felt they weren't always able to access support when needed.

Similarly, when asked about access to activity most patients indicated they were happy with the range and amount of activity offered. With regards to time in bedroom through the day 36 patients felt they spent the right amount of time in their bedroom, eight answered "no", seven answered "sometimes" and the remaining two did not return a response. Feedback in this section ranged from some patients highlighting that they could be asked to go to their bedrooms after lunch each day to feedback indicating that patients found the dayroom stressful and would actually like more time in their bedrooms.

Almost all patients described their ward as clean and there were no infection control and or hygiene concerns raised.

Summary and Next Steps

- Overall, survey responses indicated that most patients felt safe and supported within The State Hospital and able to access support when needed. However, this sense of safety and level of access to support, and activity, appeared to vary across wards.
- To strengthen opportunities for learning from feedback the PCIT team will review the "Recovering Safely" questionnaire and bring this more in line with the national SPSP questionnaire (current questionnaire had underwent several adaptions at request of previous of previous PCIT Lead). Work will also be undertaken to support the data analysis stage.
- The revised questionnaire will be re-distributed in August 2025 and findings presented to Patient Safety Group in October 2025.
- To build a more detailed picture of patient's experiences of recovering safely future reports will present both "point in time" and longitudinal data to allow comparisons across clinical services.
- Feedback from the Patient Safety questionnaire will also be correlated with safety data collected by the organisation (e.g. number of restraints per service) to inform decision making.

2.4 Review patient safety data by clinical service area

Table 2 (below) details the year-on-year figures for seclusion usage across the hospital whilst Table 3 provides a breakdown of usage per service/patient for the year 2025 (inclusive of May 2025).

Table 2: Seclusions per year / number of patients

Year	Total seclusions	Total patients
2023	10	6
2024	27	16
2025 to end May	8	5

Table 3: Seclusion usage by ward/patient

Patient	Ward	Date Started	Date Ended	Reason for Seclusion	Hours in Seclusion
1	Lewis 1	01/01/25	02/01/25	Damage to bedroom property. Concern about potential to further destroy fixtures and fittings.	6hrs 30mins
2	Arran 1	02/02/25	14/02/25	Damaged to bedroom fixtures and fashioning weapons. Public Order police responded.	293hrs 5mins
3	Arran 1	21/05/24	26/05/25	Following restraint ongoing threats of violence towards staff	126hrs 15mins
4	Arran 3	10/05/25	15/05/25	Damaged to bedroom fixtures and ongoing threats of violence towards staff	115hrs 58mins

Patient	Ward	Date Started	Date Ended	Reason for Seclusion	Hours in Seclusion
5	Iona 3	03/04/25	04/04/25	Least restrictive alternative to prolonged restraint following assaults/attempted assaults on staff	26hrs 5mins
5	Iona 3	04/04/25	10/04/25	Sustained attempts to assaults/attempted assaults on staff shortly after (previous) seclusion ended.	140hrs 55mins
5	Iona 3	11/04/25	15/04/25	Ongoing assault/attempted assault on staff	89hrs 45mins
5	Iona 3	30/04/25	05/05/25	Ongoing assault/attempted assault on staff	118hrs 30mins

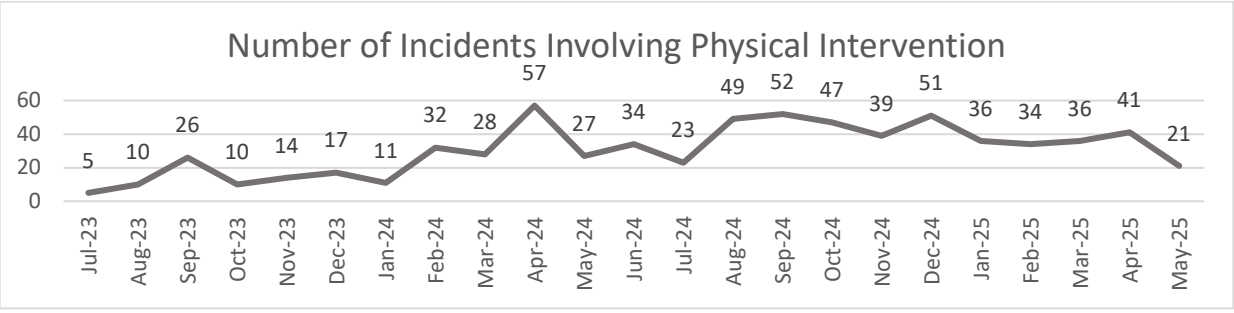
Summary and Next Steps

- The use of seclusion has been triggered on eight occasions for five patients, with one patient requiring seclusion on four separate occasions.
- To date, there would appear to be a reduction in the use of seclusion over 2025 compared to the previous year.
- Seclusion has been used within the admission wards on three separate occasions (1 x Lewis 1 and 2 x Arran 1); once in the Treatment and Recovery Service (Arran 3) and on four occasions (for the same patient) within the Intellectual Disability Service.
- The length of time each patient has spent in seclusion has ranged from approximately 6.5hrs through to 293hrs.
- One patient has required seclusion for a cumulative period of approx. 375hrs (15days) across a four-week period for sustained assault/attempted assault towards staff.
- Due to relatively low numbers the use of seclusion is monitored on a case-by-case basis.
- Audits are benchmarked against the hospital's Seclusion policy.
- Seclusion of restricted patients is reported to Scottish Government by the clinical Quality Department.

Physical Intervention

Over the reporting period the hospital has experienced approximately 39 PMVA incidents per month, with the lowest number of incidents in May 2025 and the highest in September and December 2024 (with 52 and 51 incidents respectively). Table 4 (below) tracks the number of PMVA incidents per month since July 2023.

Table 4: Incidents involving Physical Intervention



Tables 5 (redacted for anonymity reasons) and 6 (below) provide a breakdown on PMVA incidents by ward and clinical service from July 2024-May 2025.

Table 5: Incidents per ward

Table 6: Incidents per clinical service

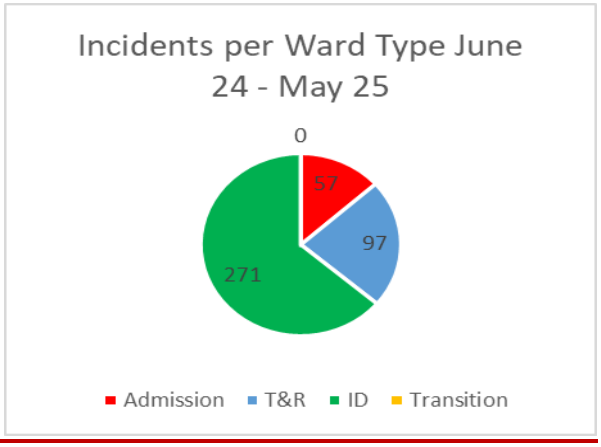
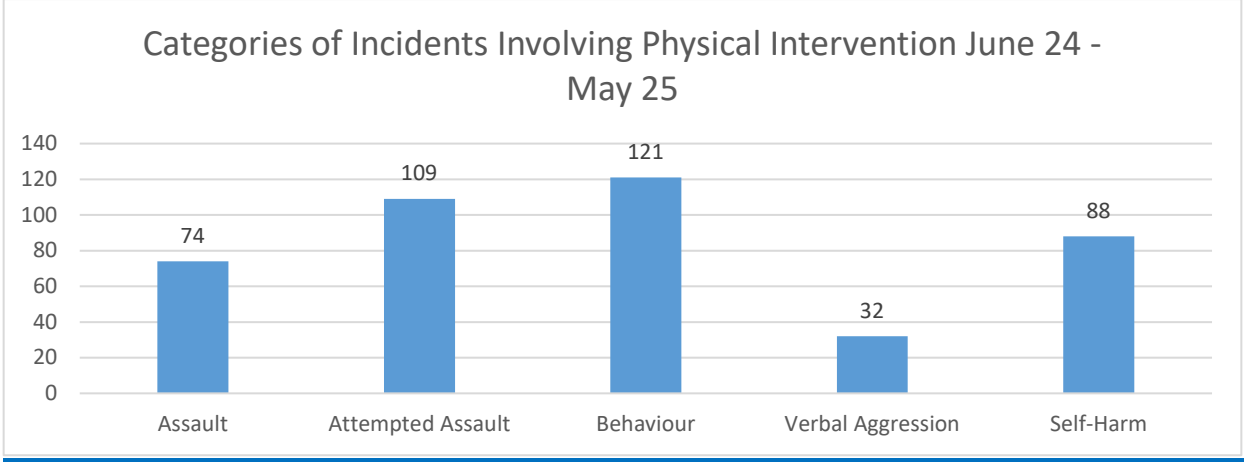


Table 7 (below) outlines the types on incidents which have resulted in the use of PMVA.

Table 7: Incident Categories resulting in PMVA



Summary and Next Steps

- Physical Intervention incidents remain the highest in the ID service, in line with the number of violent and aggressive incidents recorded.
- Physical intervention incidents in Lewis 1 admissions service were almost five times higher than the number of incidents in Arran 1 service.
- Similarly, Lewis Admissions and T&R service have collectively experienced almost three times the number of incidents in the mirroring Arran services (120 versus 34).
- The Transition Service have had no PMVA incidents during the reporting period..
- Both ID wards have been responsible for the majority of all physical intervention incidents within the hospital. This has significantly increased over the last 12 months.
- T&R follows with 97 although it should be noted that there are 4 wards in this cohort, and more than half of the incidents come from one ward and involve 1 patient..
- Threatening and Intimidating Behaviour was the highest recorded reason in for Physical Intervention being used followed by Attempted Assault and Assault.
- Concern has been previously noted around the number of “behaviour” incidents resulting in physical intervention. A review of the data highlights that there is often a violent aspect to the behaviour such as damaging rooms, throwing furniture or making serious threats. A number of the incidents have also only resulted in non-secure holds not full PMVA techniques being deployed however these are currently being recorded as physical intervention.

- The Risk and Resilience Department are working to ensure that all incidents are appropriately recorded to ensure accuracy and working on a longer-term solution to pull recorded data more accurately.

Other Incidents of Note

- Two Category 2 reviews have taken place in the last 12 months both relating to patient fractures during PMVA restraint. The recommendations from one have been published with the publication of the second report imminent.

Self-Harm

Table 8 (below) outlines the number of self-harm incidents per month over the reporting period and Table 9 (redacted for anonymity reasons) details a breakdown of these incidents per ward

Table 8: Self-Harm incidents per month

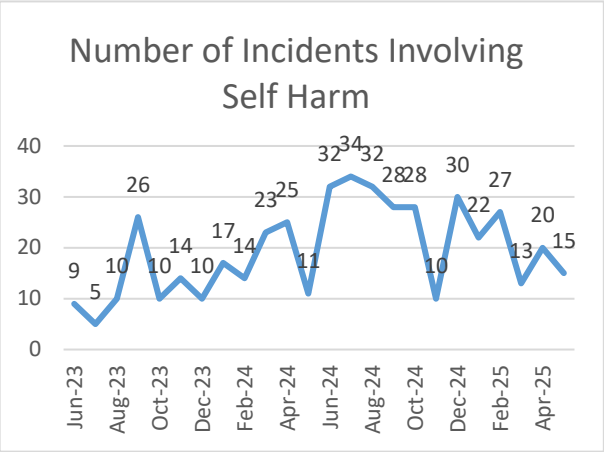


Table 9: Self-Harm incidents per ward

Summary and Next Steps

- The number of self-harming incidents remained relatively consistent between June and Dec 2024 (apart from October 2024 where recorded incidents significantly dropped)
- The majority of incidents in all months are from a very small cohort of patients
- All incidents recorded in Ward X were attributed to X patients and most incidents recorded in Ward XY were also largely attributed to X patients.
- There were no self-harming incidents recorded in the Transitions Service.

Other Significant Incidents

Over the reporting period there were two Incident Command events whereby patients managed to destroy fixtures and fittings within their bedrooms. Both occurrences result in the Incident Command structure being enacted, and on one occasion the deployment of Level 3 PMVA staff. These incidents are currently being written up as Category 2 Reviews to establish any further learning.

2.5 Reporting of medicines management by clinical service area

Over the reporting period, Lewis 1 recorded the highest number of medicines incidents, followed by Arran 2 then Lewis 2. This differs from 2023/24 where the highest number of recorded incidents were nine in Lewis 3 followed by seven in Arran 1, 2 and Lewis 1, then six in Iona 2.

Table 10 (below) offers a breakdown of medication incidents per ward; Lewis 1 recorded the highest number of administration (21) and prescribing (3) incidents. The next most reported administration errors were in Lewis 2 (6) and Mull 2 (5).

Table 10: Medicines incidents per ward 2024/25

Category	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8	Ward 9	Ward 10	Ward 11
Administration	4	4	3	21	6	3	1	1	1	1	5
HEPMA	0	0	0	1	2	0	0	0	0	0	0
Supply	2	4	3	2	0	0	0	0	0	0	1
Prescribing	1	1	0	3	0	0	0	0	0	1	0
Total	7	9	6	27	8	3	1	1	1	1	6

Despite the marked difference in recorded administration errors there are no concerns about practices within a specific hub, service or ward. Overall, the number of recorded medicines incidents remains low. Members of the Patient Safety group continue to discuss the possibility of some wards under-reporting medication errors, and all wards are encouraged to report all near misses to allow learning, adaptations to practice from learning, and ultimately to minimise unnecessary opportunities for harm.

Whilst a range of incidents were noted across the reporting period, there were also some more common medicines administration themes:

- Medicine charted in error (16).
- Found/secreted tablet (12).
- Missed dose (5) .
- Medicine not charted (4).
- Withheld drug charted in error (only one recorded but three other recorded incidents in relation to clozapine plasma levels).
- Incorrect medicine (3) or dose given (3).

To support attempts to reduce the incidences of these more commonly noted medicines incidents a number of improvement actions have been agreed and bi-monthly meeting updates continue to be provided by the Lead Pharmacist (in addition to six-monthly and annual update reporting).

2.6 Promote psychologically safe working environment through debrief process

Work to ensure debrief forms part of routine practice in The State Hospital remains ongoing. Over 2024 members of the Nursing Practice Development Team worked with colleagues from the Risk Department to develop a debrief guidance document for all clinical staff with testing in identified wards, using a Quality Improvement approach. This guidance document will now sit as an appendix within the PMVA policy (which already signposts to debriefing following all restraint incidents) and longer term the NPD team will undertake further work to create standalone Debrief guidance and support documents to be used following any incidents where debrief would be viewed as helpful or essential.

In addition to the above, amendments have been made to DATIX forms to ensure all PMVA related debriefs (in the first instance) are documented within the DATIX platform alongside all learning points which will be shared via the Patient Safety forum to support ongoing learning into practice. Work to promote the importance of debriefs (and subsequent recording of these) remains ongoing.

2.7 Engage with the Quality-of-Care SLWG, and trial the collaboratively developed Quality of Care documentation within TSH (Quality of Care Reviews)

Following national launch in September 2024 members of the Nursing Practice Development Service have been working with colleagues from Health Improvement Scotland and NHS Forth Valley (FV) to progress Quality of Care visits at the State Hospital using the Excellence in Care "Once for Scotland" Quality of Care review guidance.

The first official independent review was undertaken by colleagues from NHS FV on 14th May 2025 in Mull 1/Transitions Service with, overall, positive feedback. THe hospital received one recommendation in relation to avoiding patient harm through the use of DTC to manage resource challenges. As noted in Section 2.2. actions to address this recommendation have now been met.

To support embedding of Quality of Care visits, the Associate Director of Nursing has also met with the Forensic Network Manager and Director of the Forensic Network for Scotland to discuss opportunities to review and map the EiC Quality of Care guidance against the already existing Continuous Quality Improvement (CQIF) standards developed for forensic services in Scotland. This would create potential opportunities for peer reviews to be undertaken across all inpatient forensic services in Scotland using a standardised approach whilst also meeting the requirements of Excellence in Care.

In addition to the above noted updates, the Patient Safety Group commissioned a distinct piece of work to review SRK practices across the hospital following a noted increase in usage over 2024 and early into 2025. This piece of work was undertaken by the Lead PMVA Advisor and the Head of Clinical Quality. SRK usage was examined on a case-by-case basis and cross referenced with episodes of Seclusion to determine any trends or patterns in usage and, therefore, any areas of concern and/or learning. The report concluded that whilst all episodes of SRK were deemed to be appropriate and proportionate to the risk circumstances presented there were opportunities to improve upon elements of the process and monitoring paperwork, alongside opportunities to support graded approaches to SRK usage in the Learning Disabilities and Women's Service. Findings from the report were presented at May's Clinical Governance Group and the June (2025) Patient Safety Group thereafter.

3 QUALITY IMPROVEMENT ACTIVITY

Description of work stream	Update	Status
Engage with national SLWG to develop a more standardised approach to Quality and Safety walkarounds.	As noted above	Complete
Review format and outputs from current Quality and Safety visits and consider areas for improvement	As noted above	Complete
Implement new Clinical Care policy, incorporating principles of the Improving Observation Practice framework.	As detailed above.	Complete
Review Debrief Process and Implement learning	As detailed above	Ongoing
Commission Short-Life Working Group to review increased SRK usage over 2024.	As detailed above	Complete

4 PERFORMANCE AGAINST KEY PERFORMANCE INDICATORS (KPIS)

Over 2024/2025 The State Hospital has continued to have representation at national Patient Safety meetings and/or learning events. The Associate Director of Nursing continues as the lead representative for the hospital and the Lead PMVA Advisor/NPD team member as deputy. The Director of Nursing remains Sponsoring Director with oversight of the Patient Safety Group workplan. Six monthly and annual update reports are provided to the Clinical Governance group with the annual reporting to the Clinical Governance Committee.

The hospital continues to monitor a number of patient safety indicators including those noted in this report in addition to areas such as complaints; staff resourcing; patients requiring Enhanced Care; and additional staff required to support Enhanced Care. Auditing of policy compliance continues to be undertaken by the Clinical Quality Department (as outlined in Section 5).

5 QUALITY ASSURANCE ACTIVITY

Colleagues within the Clinical Quality Department continue to audit compliance against several policies pertaining to safe patient care, including those detailed in the table below, with regular reporting to the Patient Safety Group and actions/learnings identified and implemented as necessary.

Policy	Implementation/Review Date	Next Review	Audit Cycle	Points for Noting
Clinical Care (CP57)	01/05/24	01/05/25	12-month review now underway	As per update (above) RSM audit now complete allowing internal audit to commence.
Mechanical Restraint (PMVA 3)	27/04/2024	27/04/27	Case-by-Case Basis	As per update. Following a noted increase in SRK usage over 2024 the Patient Safety Group commissioned a review of SRK usage alongside compliance with policy.
Physical Intervention (PMVA5)	04/09/24	04/09/27	Quarterly	Minor amendments made to policy wording; updates to evidence base; and inclusion of trauma informed practice.
Seclusion (PMVA 6)	01/05/24	01/05/27	Annual Case Studies (due to very low numbers of seclusion per year)	Policy reviewed and updated to incorporate monitoring and reporting of Level 1 and Level 2 Seclusion – as per Mental Welfare Good Practice Guidance (2019).
Use of PMVA Personal Protective Equipment (PMVA 7)	21/02/23	21/02/26	Case-By-Case Basis	Policy enacted in February 2023 and to date there has been 1 incident (Jan 2025) which resulted in the deployment of Level 3 staff .

6 QUALITY IMPROVEMENT ACTIVITY

Over 2024/2025 members of the Patient Safety Group continued to engage with SPSP colleagues and colleagues from other Health Boards to support the successful implementation of the new Clinical Care policy. The collaborative provided TSH staff with the opportunity to engage with other mental health services, both in terms of sharing successes and in sharing lessons learned from attempts to implement the framework in other areas.

As detailed in Section 3, a number of other improvement projects have been undertaken including improvements to debriefing and the introduction of Quality-of-Care visits.

7 REVIEWING AND MONITORING OF NATIONAL CLINICAL GUIDELINES AND STANDARDS

Over the review period the Patient Safety Group were involved in the review of one standard / guideline from Mental Welfare Commission titled “Rights, Risks and Limits to Freedom”. This was an updated document published in May 2025 therefore a full matrix was not required however one section relating to soft mechanical restraint is currently being reviewed for any gaps in current practice.

There are currently five outstanding recommendations in relation to the previous Rights, Risks and Limits to Freedom that have been achieved with a further 5 outstanding recommendation with progress ongoing. An Action Plan tracking progress on the work to meet these recommendations is monitored by the Patient Safety Forum.

8 STAKEHOLDER EXPERIENCE

Engagement with stakeholders remains a key priority for the Patient Safety Group. Over the coming year outputs from the priorities undernoted will be fed back to patients via the Patient Partnership Group with the support of the Person-Centred Improvement team. Likewise, any organisational learning or areas that require action will be discharged to the most appropriate forum.

9 LANNED QUALITY ASSURANCE/QUALITY IMPROVEMENT FOR THE NEXT YEAR

Key priorities for 2025/2026 include:

- Undertake one year review of Clinical Care policy.
- Support eradication of Daytime Confinement through monitoring potential patient harms associated with this practice.
- Monitor patient safety data by clinical service area and commission any discrete pieces of improvement work as necessary.
- Repeat patient safety survey for 2025.
- Continue with regular reporting of medicines management.
- Support improvement activity in relation to ensuring debrief form part of routine practice.

10 NEXT REVIEW DATE

The next review date will be July 2026.