Patient Safety Plan 2026-2028

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	NAME	TITLE	DATE
Author (s)	Jo Scott Patrick Neville	Group Director QA & PSIRF Project Manager Development Director	
Reviewer	Prof. Quazi Haque	Chief Medical Officer & Exec project lead PSIRF	**01.12.2025**
Authoriser	**Corporate Clinical Governance Meeting**		**13.01.2026**

Contents

1. Introduction

Patient Safety Incident Response Framework (PSIRF) was implemented in September 2023 across all Elysium services, and this is now the refreshed second edition of the Patient Safety Plan (PSP) for 2026-2028.

This patient safety plan sets out how Elysium Healthcare intends to respond to patient safety events over the next two years. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and events occurred and the needs of those affected.

This plan should be read in conjunction with the Patient Safety Incident Response Framework (PSIRF) Policy and Ch23 Incidents and Untoward Occurrences (inc PSIRF) Policy.

2. Our Services

Elysium Healthcare is an Independent Healthcare Provider it is comprised of the following services:

- 96 sites with 2449 beds across England and Wales
- Our services are hosted services in the majority of ICBs across England, Health Boards in Wales and with service users from all areas of the United Kingdom, and other jurisdictions.

PSIRF methodologies are used across all our services, including our services in Wales and Local Authority funded services, to ensure a consistent and safe system providing one patient safety system across the Elysium Group.

We provide a range of services working with partner organisations across health and social care, as part of these partnership arrangements we may be in local networks or wider Provider Collaboratives. No matter what types of relationships we have it is always important that we as a company maintain our own clinical leadership and support our services to provide safe and good quality care. As part of maintaining corporate oversight of quality and safety we group our services within Elysium Clinical Networks. Our services within Elysium Clinical Networks work together to ensure the support necessary to provide innovative care, quality assurance, patient safety, and inter-service peer support.

The following are our Clinical Networks:

- Secure
- Acute/PICU
- CYPMHS
- Adult Eating Disorders
- Neurological

- Rehabilitation Hospitals (Male)
- Rehabilitation Hospitals (Women)
- LD/ABI Hospitals and wards (secure and non-secure)
- Care Homes (Qualified Nurse)
- Care Homes (No Qualified Nurse)

The make-up, structure and utility of the Clinical Networks is monitored through Corporate Clinical Governance (CCG) to ensure their functionality within their defined role. It is of note that the type and range of inpatient services provided by Elysium is far wider than an NHS Trust and geographically distanced from each other. Secondary to the complexities of range and distances between services is that the individual services are separately registered to the CQC / HIW. This separation of registration between individual services means that an NHS Trust divisional approach to setting patient safety plans is more complicated within the independent sector. We bring services together within a network model to ensure learning, the sharing of learning and the ability to effectively review the patient safety improvement plans.

3. Refreshing our patient safety incident profile

Elysium has always maintained central corporate oversight of incidents both in the reporting (via IRIS) and the management of incidents using the previous Serious Incident Framework (SIF) system and since 2023 PSIRF.

Initial Patient Safety Plan 2023-2025: We undertook a mapping exercise to review three years' worth of IRIS (our incident recording system) and SIF data to extract themes and cross reference this with three years' worth of Safeguarding, Health and Safety, Human Resources (disciplinary), duty of candour, complaints, and claims information. This gave us a rich but complex data source.

With this large data set the working group agreed a set of key priorities to form an indicative patient safety incident profile that was used to map the data available on all our electronic systems to triangulate the key themes that derive from all incident reporting.

The Key Themes (fig 1.)

Direct - Patient safety issues that are well known to services and the company with associated data though reports and historic action plans	**Indirect -** Suspected or known patient safety issues, such as contributory factors with or without wider knowledge that are not always supported by direct correlation or specific mention in reports	**Unique -** One-off events are important as they will always require investigation and by their very nature cannot be covered in a patient safety plan, beyond the need to know that a response will be required.
1. Patient Supervision and Observations 2. Medication Management Errors 3. Self-Harm 4. Patient Violence towards others 5. Restrictive Practices 6. Accessing, granting, or breaching leave 7. Environmental factors 8. Physical Healthcare 9. Mental Health Act – process breaches of all types	10. Workforce 11. Patient Mix on ward/care home 12. Inappropriately placed Patients 13. Delayed Discharge 14. IT and BCP issues in care delivery 15. Care Planning Quality – or failure to follow. 16. Communication issues	17. Unexpected death will always fall into this category. 18. Random unique incidents that we would be negligent if we did not review/ investigate

During the PSIRF implementation process (2022-2023) the key themes were shared with NHS commissioner organisations through their participation in our working group and stakeholder events. It should be noted that as a large multi-site provider Elysium is a significant provider of NHS and Social care services but from the point of view of the individual NHS and Social care commissioner it is more relevant for them looking at individual service user experience rather than a view of us as a large multi-site provider. This conflict in perception means that the NHS / Social Care view of the range and type of our patient safety incidents is wholly dependent on their use of our services, which may not include the wide spectrum of services that we provide and indeed mostly reflects an individual's care. Therefore, their ability to confirm or validate the range of patient safety incidents can be limited / biased on a companywide view. It is worth noting that from their wider system experience of all providers none of the NHS commissioners noted anything abnormal or missing from the key themes list for the Initial PSP 2023-25.

Refreshed Patient Safety Plan 2026-2028: In this refreshed PSP the table above *remains valid* as it captures the patient safety profile of all services within Elysium. Since 2022/23 we have a greater understanding of the Elysium Safety Profile and have a more detailed and consistent understanding of the PSP through the review of all escalated events at the weekly Patient Safety Meeting (PSM). In the

first two years of PSIRF no other significant patient safety events have emerged that would alter this view.

We have therefore decided that this Key Themes list will continue to be the basis of the Elysium Patient Safety Plan 2026-2028 and the profile that it will be based upon. The data that we have now accrued allows us to revise our ambitions initially set out and establish our priorities based on information that has been validated through a rigorous oversight function at the PSM.

There are some basic system rules used to support learning and ensure effective use of the PSP.

1) Services with a significant proportion of temporary staff (including agency workers) on duty at the time of a patient safety event should always opt to undertake a learning response approach, especially where there is doubt an improvement response pathway/or local systems and polices would be known to the staff on duty in a meaningful way. The agency staff will be invited to attend.

2) Services that are new or undertaking a change in practice to a new patient group will be supported to establish a local improvement plan that should ensure that all patient safety events are reviewed through a learning response process until assured practice is meeting the expected level of compliance.

3) The Patient Safety Meeting (PSM) will maintain a PSII (Patient Safety Incident Investigation) – database centrally run and assign reference numbers to any incident being investigated using the PSII methodology and paperwork.

4) As part of the regularly reviewed patient safety profile information, the Patient Safety Meeting (PSM) will receive reports detailing:

    i. When requested the safety plan for those individual's collecting significant numbers of events (out of kilter with the usual presentation within service) – those falling into this category will be identified through the monthly mapping reports.
    ii. Those within our services escalating beyond the services expertise – where notice has been served to commissioners. The Patient Safety Meeting (PSM) should on a regular basis review the plan and actions being taken to resolve (see Form P2 in appendix).
    iii. All delayed discharges should on a regular basis have a review of the plan and actions being taken. (see Form P2 in appendix).
    iv. The Patient Safety Meeting (PSM) will be notified of any incidents that fall into the following categories, within the network / service PSP there is a pre-agreed response to some of these which will include to enact a learning response or confirm supported by the improvement response pathway (see Form P1 in appendix):

        a. Any safety incident that has required the individual to be escalated to general hospital

b. Any safety incident that potentially there will be staff disciplinary action
c. Any safety incident that the police are asked to respond to and/or a 999 call made to emergency services
d. Missing service user
e. AWOL (Detained patient)
f. Escape from within service and absconding from escorts
g. Failure to return from leave
h. Any safeguarding incident going to a Section 42 England; Section 126 Wales; Section 47 Children.
i. Any incident that triggers Duty of Candour
j. Mental Health Act breach leading to illegal detention
k. Any incident that compromises the safety of the unit
l. Any incident that has media interest
m. All deaths
n. All significant incidents that are not included in the above where the service, region, network, or the board chooses to escalate

5) P3 Report: The PSM will raise a P3 report (see P3 form in appendix) to the Elysium Executive when a patient safety event is of such significance the board should be alerted immediately.

The P3 incident will be:

- An outlier, as a rare event of significant concern that may indicate quality or safety issues on a wider basis than the reported incident itself.
- The P3 incident falls outside of a PSIRF response process to manage the incident it will involve other agencies. The incident may not be subject to solely or specific Elysium investigation (such as HR) as it is either a safeguarding and/or police matter. It is possible that the individuals involved are employed by third parties (agency).
- The P3 incident has either a potential for extreme impact when it occurs or may cause serious issues for patient safety, media interest or staff/public safety.
- These will all be incidents that the company will want to keep an auditable record of actions taken.

The P3 is raised by the chair of the PSM meeting to the executive team and the Risk Committee.

6) Clinical Note of Concern (CNC) (see example in appendix): The PSM will issue a CNC when there is clear thematic evidence of a practice issue affecting patient safety. PSM notifies the CCG with an issue of clinical concern including the suggested recommendations to support action and governance with regards to how the issue could be reviewed / addressed. This is to enable the PSM to hand over concerns to enable them to be clinically / operationally addressed.

7) Mortality: The PSM has the responsibility to review all expected and unexpected deaths. To confirm and recommend any learning response required to review the death. The PSM sets

the TOR, monitors and reviews the draft report and recommends to the CCG publication. The PSM maintains a record of all deaths and provides data to the Mortality Oversight and Prevention Group.

8) There is an on-going constant review requirement to maintain effective relevant and up to date PSP. This review process will occur every 18 – 24 months. The reason for this is to ensure a whole refresh of the entire patient safety system to give assurance at board level that all patient safety processes are maintained to a high level of PSIRF compliance.

9) Safety Bulletin: This is a quarterly bulletin that shares PSM identified issues of safety and practice, themes and data. This is shared with all services and is externally published on our website (see issue 7 in appendix).

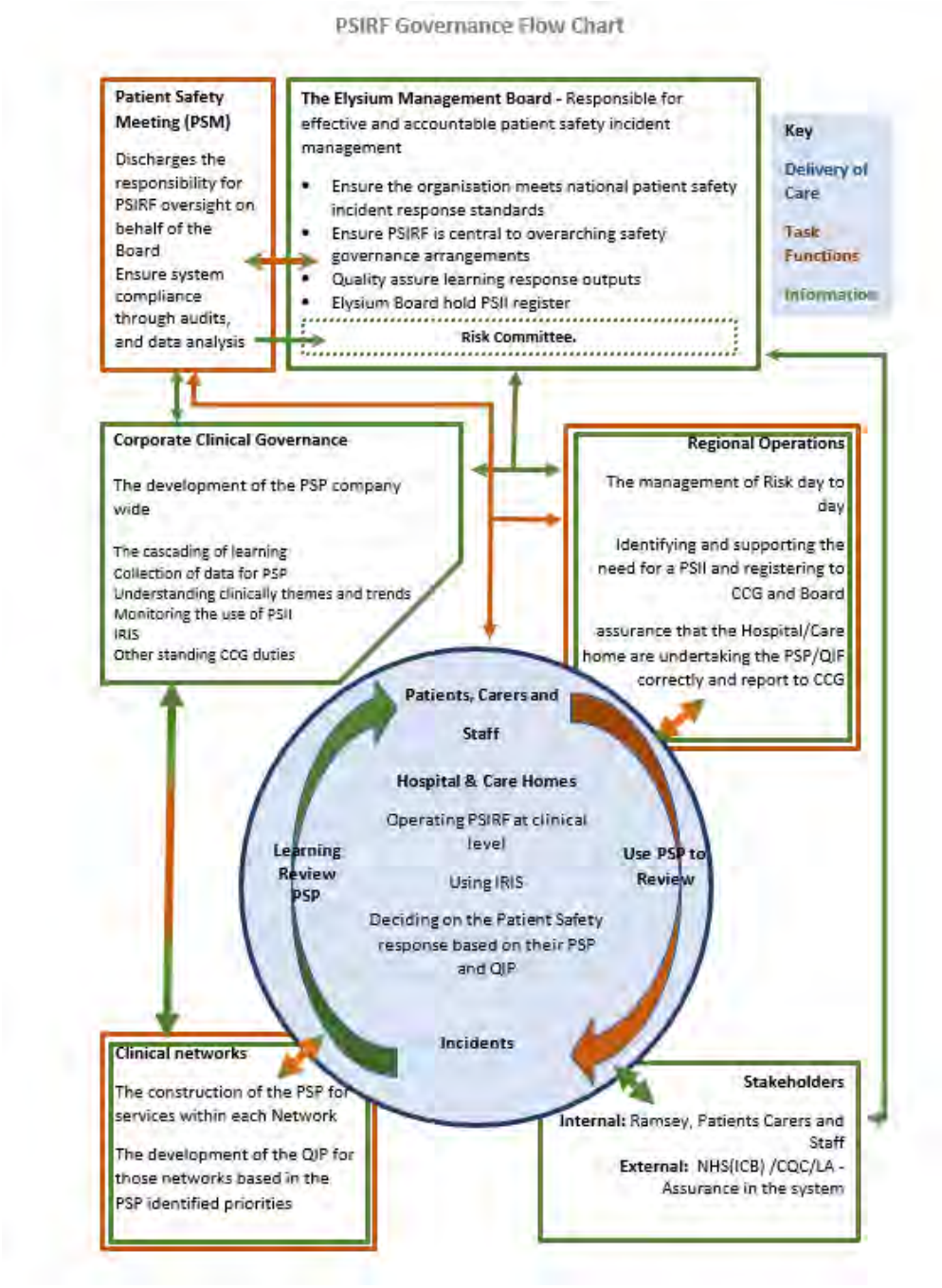
4. Defining our patient safety improvement profile

Elysium developed its governance processes to continually gain insight from patient safety events and this feeds into quality improvement activity. We continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we undertake. The governance architecture supporting PSIRF, including the clinical networks, are being reported through Corporate Clinical Governance (CCG) to ensure there is timely engagement with the operational side of Elysium. Patient safety is the responsibility of the whole organisation and should never be seen solely as a clinical issue.

The Risk committee provides assurance to the Elysium Management Board that quality improvement measures which require development and implementation continue to be of the highest standard. CCG will be responsible for the oversight of this quality improvement work including the robust use of quality improvement methodology such as Qi (Quality Improvement) which is supported by the Quality Improvement Team. Services and regions also report through CCG on all types of improvement work and developments undertaken, that will also include patient safety actions. *See PSIRF governance structure below fig 2.*

Our clinical networks and regions are required to report to our CCG in order to monitor and measure improvement activity across the organisation. This provides assurance during the development of new safety improvement plans following reviews undertaken within PSIRF to ensure they have followed robust processes during development and fulfil SMART (Specific, Measurable, Attainable, Relevant and Time Bound) requirements and are sufficient to support Elysium to improve patient safety in the future. It is important to note that flexibility to consider improvements as required, where a patient safety issue emerges from ongoing internal review or external information, remains supported.

Fig. 2



5. Our patient safety plan: National Requirements

Elysium, as with all healthcare providers resourced through the public sector, has finite resources for patient safety incident response. We intend to use those resources to maximise improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety events based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety events, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of events which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but Elysium fully supports this approach as it fits with our aim to learn and improve within a "Being Fair to All" approach (NHS Guidance).

As well as PSII, some incident types require specific reporting and/or review processes to be followed. For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in the table below (Fig. 3)

Fig.3

Event	Action required	Lead body for the response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)[5]	Locally-led PSII	The organisation in which the event occurred
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII	The organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement.	Proportionate learning response	The organisation in which the Never Event occurred

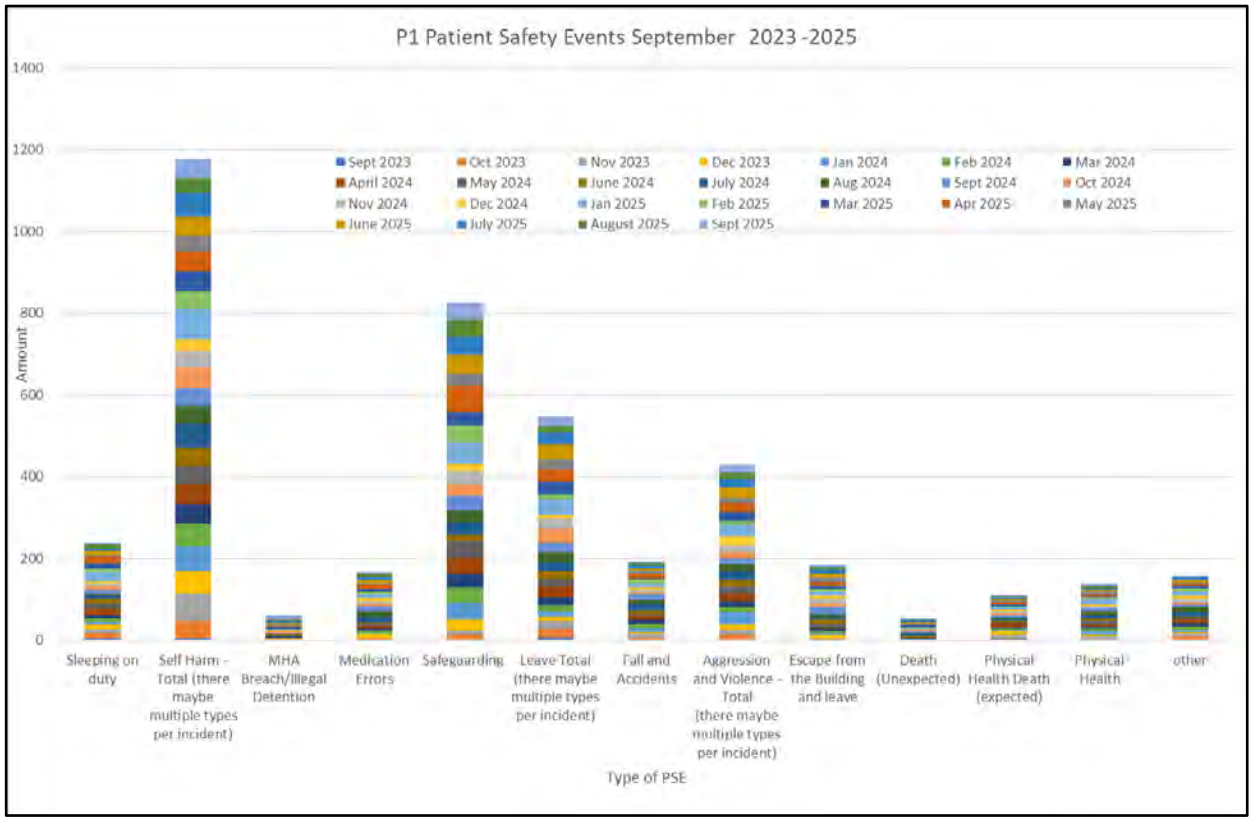
Event	Action required	Lead body for the response
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	As decided by the RIIT
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII See also Appendix B	HSIB (or SpHA)
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Child Death Overview Panel
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	LeDeR programme
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Refer to your local designated professionals for child and adult safeguarding

Event	Action required	Lead body for the response
• adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence		
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	The organisation in which the event occurred
Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so	PPO or IOPC
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case	CSP
	Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	

6. Our Patient Safety Plan: Local Focus (refresh)

This refresh of the PSP is building on the original PSP (2023-25) and using two years of learning since the implementation of PSIRF. This includes all the monitoring of patient safety events at the Patient Safety Meeting (PSM). We have maintained a database of all escalated (P1) reported events and have reviewed a range of patient safety learning events, including all PSII.

Chart 1. P1 escalation 2023-2025



What the data tells us about changing the PSP priorities

The refreshed PSP focuses on improvements to practice where we can influence patient safety, rather than the previous focus on symptomology. The aim is to ensure we focus on improving how we are caring rather than attempting to bluntly reduce the amount of patient safety events that are occurring. This set of patient safety priorities aligns to this ambition and ensures that the plans are amenable to staff skill /practice focused improvements.

Initial PSP 2023-25 - there have been 4359 escalated patient safety events (via P1 forms) between September 2023 -2025 (see chart 1.) The table (Fig.4) below highlights the actions and achievements to date in relation to the 2023-25 PSP.

Fig.4.

PSP Priority	Actions to date
Patient Violence to others – focussing on abuse, aggression and physical	• Agreed Position with regards to Zero Tolerance and supporting Patients & staff to report incidents to the Police • PSM ask sites to include Regional STMVA lead in any review of restraint/violence management – to support site and corporate learning – STMVA Director is a standing member of PSM • Use of mechanical restraint and identifying need for policy improvement • Lone working and safe management of staff in isolation. • Mappa compliance improvements

	• **Two PSII – relating to aggression and violence**
Self-Harm – All categories	• Introduction of Head Injuries Management through the PHG • Draft revised observation Policy • Revision to the ligature policy • Improvement to emergency response BLS and ILS • Ingestion Risk, environmental improvements to reduce access • Safety Clothing and consistency of supply/quality/wear etc • Delays in access to treatment at A&E and inter service liaison. • Plastic bags and service control of risk • Access to national TOXBASE • **Seven PSII – Relating to self-harm events (five ligatures)** • **Three P3 were raised (2 relating to ligature)**
Medication Management – administration and dispensing errors	• Noted that most medication events are not reaching P1 escalation level and are managed at site • Common themes within P1 – Misidentification of patient, dose errors, secreting medication to OD, breach in safe management of drugs, MHA breaches (T2) • **One PSII relating to medication management** • **One P3 in dispensing of prescribed feed.**
Physical Health Care – Neurological only	• Patient Safety Events, relating to physical health for the PSM are where there are breaches in care. • Improving the management of transfers of care between General Hospital and Neuro services. • **Two PSII- Death of patients relating to care and treatment**

Note

There were an additional four PSII relating to safeguarding (three relating to death) and eleven P3's
There were an additional eight P3 relating to environmental, security and risk concerns.

Key Patient Safety Priorities 2026-2028

The following table (Fig 5.) lists our patient safety incidents against type, and this is based on the mapping of all escalated P1 incidents reported from 2023 -2025.

PSIRF is aligned to learning and using data to formulate PSPs. It is worth noting that the management of patient risk is not solely a PSIRF issue, as the need to develop systems and models of care will always include practice development and learning from research and best practice. Patient safety incidents and their outcome with the subsequent learning will always be used to improve the planning to manage patient safety events.

The following table is the key priorities analysed by the data from IRIS/ P1 reports.

Fig.5. **Patient Safety Key Priorities 2026-2028**

Patient SafetyEvent[1]	Approach	Improvement
ABUSE		
Physical	**Aggression and Violence Prioritised in PSP this year** This priority will be supported by central plans across all services. These plans are not	The focus of the PSP is to ensure staff ability to manage aggression and violence with support and training

[1] These are the general rules for managing incidents with PSIRF – although it must be understood that any incident can be investigated as requested by the Patient Safety Meeting (PSM), the service, or external stakeholders request.

	solely within the remit of PSIRF	
Verbal (including Hate Incidents)	**Aggression and Violence Prioritised in PSP this year** This priority will be supported by central plans across all services. These plans are not solely within the remit of PSIRF	The focus of the PSP is to ensure staff ability to manage verbal aggression and violence with support and training
Hostage Taking and disturbance	A learning response will always be required	
Allegation or disclosure Coercion Psychological Sexual safety Finance Institutional /Organisational	Managed by Safeguarding	
Self-Harm		
Ingestion Insertion Self-inflicted injury Asphyxiation Food and fluid refusal Service user overdose	**Self-Harm is Prioritised in PSP this year**	The focus on care plan actions, care of harm caused and compliance to treatment goals, rather than reducing the amount of self-harm
Health		
Death	A learning response maybe be required as per policy Ch72 and advised by PSM	Learning response to support improvements to future practice
Infection control	A learning response will be required as per policy Ch46 A/B if a large outbreak or multisite occurance	To support and develop an improvement strategy to mitigate against similar occurrence
Choking Injury / Illness (inc pressure ulcers) Service user slip, trip, fall Seizure	○ If due to failure to follow care plan-safeguarding ○ If due to Self-harm – see self-harm section ○ If due to clinical change in presentation – care plan review	To support and develop an improvement strategy to mitigate against similar occurrence
Medication Management		
Administration Errors Dispensing error Prescribing error Stock issues	**Prioritised in PSP this year** Safeguarding maybe be required if there was actual or possible risk to patients	This PSE has the clearest relationship to staff practice and processes of compliance and is most amenable to local improvement plans to reduce avoidable harm.
Environmental		
Fire	A learning response will be required	H&S should lead a review of the Fire
Property and Equipment damage	A learning response maybe be required if there was actual or possible risk to patients (see aggression and violence)	Learning response to support improvements to future practice/environment

System outage (IT and utility)	A learning response will be required if there was actual or possible risk to patients safety when the BCP is required to be enacted – see Ch15 (section 6.4)	Learning response to support improvements to future resilience
Behaviours		
Disinhibited behaviour	Care Plan	Possible Safeguarding
Care planned restrictive intervention	Only a PSE if the Care Plan is breached and there was actual or possible risk to patients (see neglect)	
Misuse of tech (phone / online)	Managed by Safeguarding	
Sexual safety		
Care Issues		
Neglect – Failure to follow care plan	**Failure in Observation Prioritised in PSP this year** This priority will be supported by central plans across all services. These plans are not solely within the remit of PSIRF	Learning response to support improvements to future practice PSIRF response does not negate the need for possible HR and Safeguarding action.
MHA Implementation MCA and DoLS application or authorisation	A learning response maybe be required if there was actual or possible harm	Learning response to support improvements to future practice with the support of Group MH Administration Lead.
Self-neglect	Safeguarding and Care Plan	
Security		
Escape from care Abscond / Missing	A learning response maybe be required if there was actual or possible harm	Learning response to support improvements to future practice
Security compromise or breach High risk items (inc substance use, alcohol and weapons)	A learning response maybe be required if there was actual or possible harm	Learning response to support improvements to future practice
Data breach Cyber breach	Managed via IG	
Loss or theft	Managed as Policy Ch31	
Health and Safety		
Aggression towards staff	A learning response maybe be required – if significant disruption to clinical environment and either RIDDOR reportable, or Police response	Learning response to support improvements to future practice H&S review required if meeting H&S policy threshold see Ch5 & Ch38 See also aggression and violence above (Abuse).
Moving and Handling People Moving and Handling		

Staff slip, trip, fall	Managed via Health and Safety
Scald / burn	
Medical sharps (inc needles)	
Sharp item/surface (not needles)	
Hit by moving / falling object	
Trapped/ crushed	
Electric shock	
Road traffic accident	
Hazardous substance	

There are two PSIRF responses that feature in the decision pathway[2]

1. **Improvement Response Pathway** – defined improvement plans in place.
2. **Learning Response Pathway** – a range of proportionate learning responses (such as PSII or other tools).

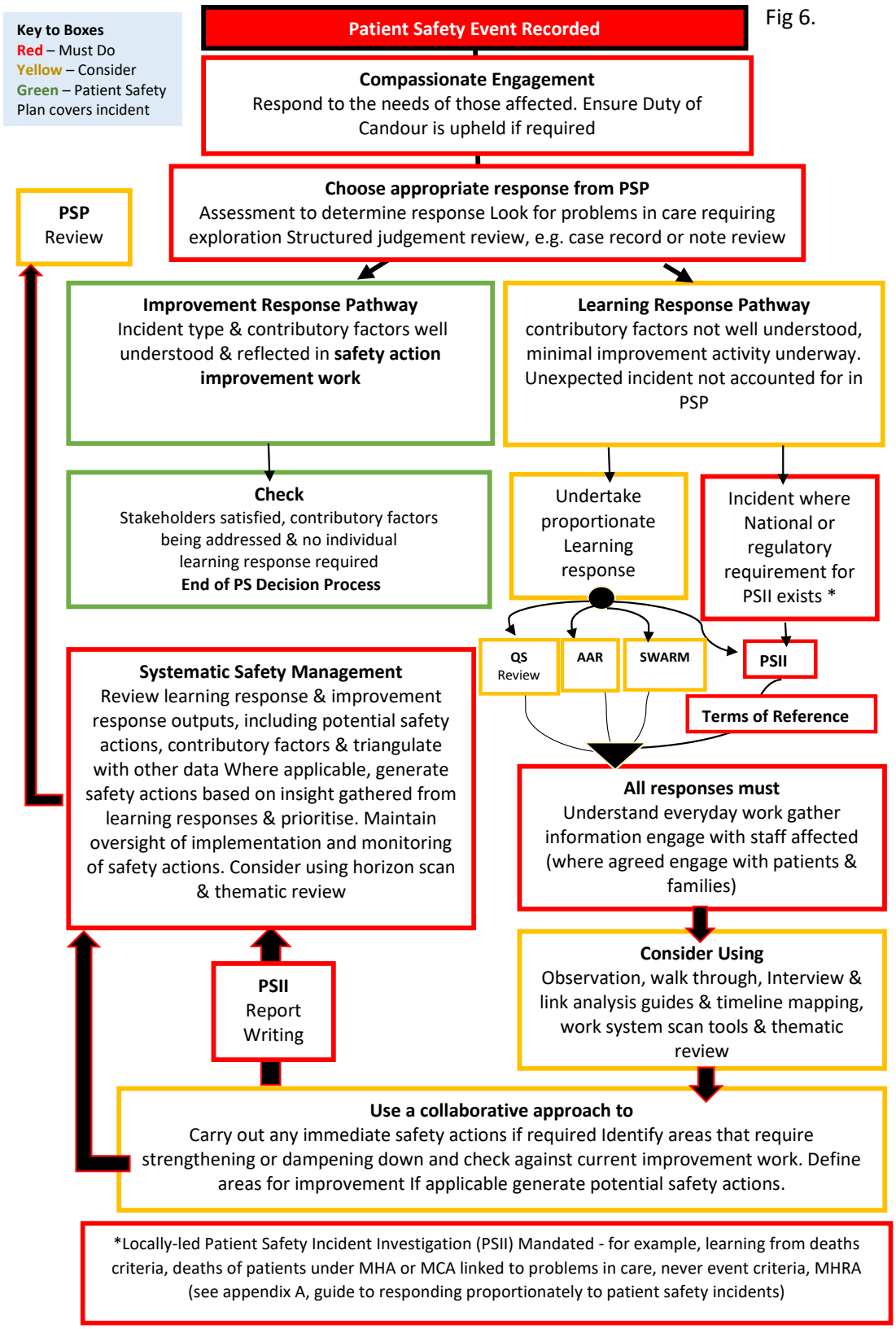
Incidents occur on a daily basis and the majority of them are immediately managed safely by the clinical team and do not require a PSIRF learning response, beyond reporting. These are covered within PSIRF Policy and are called **Not Prioritised**, this is a choice on the P1 form to confirm site response for escalated events. for example:

- Unescorted leave and not returning on time, awol policy followed and patient returned.
- Sleeping on duty is a HR matter

PSIRF does not replace, Safeguarding, HR or H&S systems these all work in parallel with PSIRF

[2] *Decision Chart following patient safety event – see flow chart below Fig 6.*

Fig 6.


Key to Boxes
Red – Must Do
Yellow – Consider
Green – Patient Safety Plan covers incident
Patient Safety Event Recorded
Compassionate Engagement
Respond to the needs of those affected. Ensure Duty of Candour is upheld if required
Choose appropriate response from PSP
Assessment to determine response Look for problems in care requiring exploration Structured judgement review, e.g. case record or note review
PSP Review
Improvement Response Pathway
Incident type & contributory factors well understood & reflected in safety action improvement work
Learning Response Pathway
contributory factors not well understood, minimal improvement activity underway. Unexpected incident not accounted for in PSP
Check
Stakeholders satisfied, contributory factors being addressed & no individual learning response required
End of PS Decision Process
Undertake proportionate Learning response
Incident where National or regulatory requirement for PSII exists *
QS Review
AAR
SWARM
PSII
Terms of Reference
Systematic Safety Management
Review learning response & improvement response outputs, including potential safety actions, contributory factors & triangulate with other data Where applicable, generate safety actions based on insight gathered from learning responses & prioritise. Maintain oversight of implementation and monitoring of safety actions. Consider using horizon scan & thematic review
All responses must
Understand everyday work gather information engage with staff affected (where agreed engage with patients & families)
Consider Using
Observation, walk through, Interview & link analysis guides & timeline mapping, work system scan tools & thematic review
PSII Report Writing
Use a collaborative approach to
Carry out any immediate safety actions if required Identify areas that require strengthening or dampening down and check against current improvement work. Define areas for improvement If applicable generate potential safety actions.
*Locally-led Patient Safety Incident Investigation (PSII) Mandated - for example, learning from deaths criteria, deaths of patients under MHA or MCA linked to problems in care, never event criteria, MHRA (see appendix A, guide to responding proportionately to patient safety incidents)

Worked Example to demonstrate how to use table and flow chart above – Patient Safety Event (PSE) – Self Harm – Ingestion

Using the Table and flow chart above the following sets out a worked example of managing a patient safety event of an episode of self-harming – A patient ingests an object, and the example sets out possible outcomes for the review of the event by the management team.

All Patient Safety Events must be recorded on IRIS and confirmed as a Patient Safety Event.

The IRIS and PSE are reviewed by the senior MDT at site and staff are debriefed (*this is not a learning event*).

What was the outcome for the patient (a, b, c or d)?

a) ***Managed at site*** – reviewed clinically and followed ingestion pathway. Clinically no need to escalate to A&E.
   - Was the self-harm ingestion in line with the known clinical presentation?
     - Yes – move on to next question
     - No – review care plan and move on to next question
   - Did the clinical team respond within care plan?
     - Yes – move on to next question
     - No – review staff actions. Was this custom and practice/system issue (Learning event AAR) or individual(s) competence (Being Fair Tool), if so, manage outside of PSIRF via HR Policy. Check escalation criteria for a P1
   - Was there any other unexpected issue with the PSE?
     - Yes – review the event and consider learning event, if not yet instigated (SWARM) and review. Check escalation criteria for a P1
     - No – end of process

b) ***Reviewed at site and escalated to A&E*** (*via* paramedics or service) Surgical intervention or not – **P1 required**
   - Was the self-harm ingestion in line with the known clinical presentation?
     - Yes – move on to next question
     - No – review care plan and move on to next question
   - Did the clinical team respond within care plan?
     - Yes – move on to next question
     - No – review staff actions. Was this custom and practice/system issue (Learning event AAR) or individual(s) competence (Being Fair Tool), if so, manage outside of PSIRF via HR Policy.
   - Was there any unexpected issue with the PSE
     - Yes – review the event and consider learning event, if not yet instigated (SWARM) and review
     - No – end of process

c) ***Emergency response required*** *(*ILS) and escalated to A&E via 999. Surgical intervention or not – **P1 required**
   - Was the self-harm ingestion in line with the known clinical presentation?

        - Yes – move on to next question
        - No – review care plan and move on to next question
    - Did the clinical team respond within care plan?
        - Yes – move on to next question
        - No – review staff actions. Was this custom and practice/system issue (Learning event AAR) or individual(s) competence (Being Fair Tool), if so, manage outside of PSIRF via HR Policy.
    - Was there any unexpected issue with the PSE
        - Yes – review the event and consider learning event, if not yet instigated (SWARM) and review
        - No – end of process

d) ***Death*** – **P1 required**, and mortality policy instigated.
    - This will be a PSII, and the Patient Safety Meeting will set TOR and appoint investigators

7. Assurance of the mapping process – ensuring validity

The Patient Safety Meeting (PSM) maintains a process of quality control and oversight to ensure compliance to our high-quality expectations for the patient safety system; this is overseen by the Risk Committee as a standing subgroup of the Elysium Management Board.

The volume of incidents is large, but the following table (Fig 7) sets out our key priorities in relation to the number of incidents.

Self-Harm (24.7%) is the most consistently and frequently escalated patient safety event to the Patient Safety Meeting (PSM). Incidents related to leave and AWOL make up 23.5 % of all P1 reports. We monitor aggression and violence that have escalated on a P1 so that we understand the range of risks at our services. Aggression and violence accounts for 9.75% of P1s and violence towards staff is the majority of incidents. Safeguarding (26%) accounts for a significant amount of PSE reported, this includes sleeping on duty, missed observations, allegations of abuse and neglect.

The majority of the P1 forms submitted to the PSM relate to service user action. This is not unexpected within the services we provide considering the risk to self or others is the major reason for admission within a population who are mostly detained under the Mental Health Act 1983.

Patient safety events related to staff interaction/actions with patients, such as observation, both failures to follow care plans and other related issues such as sleeping on duty, remain constant themes. Medication errors are a minority of P1 escalated with 88 cases in 2024/25, but alongside not following care plans, observation failure and error in providing appropriate care are service improvement focussed actions, that can be more directly addressed (with training, improvement plans etc) to support quality improvements.

Fig 7 **P1 Reports October 2023 – September 2025**

Type of Incident	First Year Total	Second Year Total	Total
Sleeping on duty	118	115	**233**
Self Harm - Total (there maybe multiple types per incident)	**612**	**560**	**1172**
Self Harm - cutting	60	63	**123**
Self Harm - ingestion	222	206	**428**
Self Harm - ligature	50	48	**98**
Self Harm - Insertion	89	89	**178**
Self Harm - refusing food/fluid	12	15	**27**
Self Harm - headbanging	75	61	**136**
Self Harm - overdose	27	31	**58**
Self Harm - misc	77	47	**124**
MHA Breach/Illegal Detention	17	43	**60**
Health and Safety (Patient)	41	16	**57**
Medication Errors	81	84	**165**
Safeguarding	353	472	**825**
Leave Total (there maybe multiple types per incident)	**232**	**308**	**540**
Leave - AWOL/Missing	163	185	**348**
Leave - Self Harm	21	47	**68**
Leave - other	48	76	**124**
Fall and Accidents	110	80	**190**
Aggression and Violence - Total (there maybe multiple types per incident)	**199**	**229**	**428**
A&V - Patient on Patient	58	76	**134**
A&V - Patient on Staff	141	153	**294**
Escape from the Building and leave	80	104	**184**
Media Interest	9	7	**16**
Death (Unexpected)	22	32	**54**
Physical Health Death (expected)	58	50	**108**
Physical Health	77	61	**138**
other	85	72	**157**
Totals	**2094**	**2233**	**4327**

8. Assurance of patient safety planning effectiveness

The refreshed PSP focuses on improvements to practice where we can influence patient safety, rather than the focus on symptomology. To ensure we focus on improving how we are caring rather than attempting to bluntly reduce the amount of patient safety events that are occurring. The agreed set of priorities align to this ambition and are amenable to staff focused improvements in practice.

- **Observation:** In the first iteration of the PSP we excluded Observation, fearing as a global statement it would mask actual patient safety events. We have learnt that observation failures which are included in the safeguarding and sleeping on duty column above (Chart and

table) are the highest trending number of routinely escalated patient safety events. Observation practice will therefore be one of the PSP priorities going forward.

- **Self-Harm:** Self-Harm remains as a PSP priority, but our focus will be changed to our planned care plan actions, care of harm caused and compliance to treatment goals, rather than reducing the amount of self-harm. This is simply because our admission profile will always include patients with a self-harm history and the progress towards discharge for individuals who may have reduced their individual risk of self-harm is offset by new admissions.

- **Medication Management**: Medication Management remains a PSP priority as this has the clearest relationship to staff practice and processes of compliance and is most amenable to improvement plans to reduce avoidable harm.

- **Aggression and Violence:** Aggression and Violence remain a PSP priority. Previously we were under the impression that this was not fully applicable to neurological services, but this is an erroneous assumption and is applicable to all Elysium services. Aggression and violence, alongside self-harm are the two most significant patient safety issues. The focus of the PSP will continue with ensuring staffs ability to manage safely, with support and training for the range of behaviours of violence and aggression from patients.

Physical Healthcare (Neuro) which was a priority in the initial 2023-25 PSP, will no longer be a PSP priority. The number of clinical notes and nonpatient safety events that are entered into IRIS, especially the correct escalation of physical health care (which is not a PSE), means that the data relating to patient safety events correctly escalated to the PSM, that are physical healthcare, are low (see chart 1). The patient safety events that are abuse and neglect are safeguarding events, not physical healthcare events.

In all cases poor care (abuse) is a matter for safeguarding investigation. These events are raised at the PSM using a P1, and this will continue.

9. Staff, Carer and Patient Engagement with Patient Safety planning and local improvement plans

As part of our Patient Safety Plan our ambition is to proactively engage with Staff, Patients, Families and Carers who could be affected by patient safety events with compassion, empathy, respect and transparency. The aim is to ensure safe systems of work to reduce avoidable Patient Safety Events. We accept that within our services there will be patient safety events that impact staff, patients, families and carers and we commit to engaging with those directly impacted as part of our patient safety response and review.

Patients and Staff supporting carers were engaged in the consultation for the refresh of the Patient Safety Plan to support developing an achievable process both at corporate and local service level to develop Patient and Carers involvement in improvement planning to support the refreshed Patient Safety Plan.

The following table sets out local and corporate functions

Action	Service Level	Central
Engage Carers and Patients through existing forums and the Triangle of Care framework, ensuring their perspectives inform local improvement plans[3].	✓	
Include Carers and Patients in learning responses where appropriate.	✓	✓
Share updates and Safety Bulletins with Carers	✓	
Engage Carers and Patients in developing improvement plans[3].	✓	
Host carer engagement sessions to discuss PSP priorities.	✓	
Collate feedback and integrate into local improvement plans[3].	✓	
Carer training: PSIRF, Patient safety and improvement plans - Recognising and reporting safety concerns – to be developed		✓

Staff Engagement in Improvement Planning: All staff should be involved in the development of service Patient Safety Improvement Plans through the service level clinical governance, service specific clinical networks and other local initiatives to ensure staff engagement.

Patient Safety Partners: Elysium do not have Patient Safety Partners. As an independent sector provider who works with the NHS to provide Specialist inpatient care, without resident local population responsibility, as a non-statutory provider, having Patient Safety Partners is not within the expectation of PSIRF. We have assured our process for those families impacted by significant patient safety events, both the site concerned and those assigned to investigate engage and support to ensure that families are heard and any questions built into our reviews.

[3] The Site will have multiple improvement plans and not all will relate to Patient Safety. This commitment relates to the services Patient Safety improvement Plan. The PSP relates to patient safety and patient risk behaviours not service improvements more generally.

10. Appendix

Appendix 01

PSIRF ESCALATION FORM (P1)

This form will be completed for all patient safety incidents where an escalation is required to the Elysium Patient Safety Meeting (PSM)

A copy of the form will also be sent to the responsible commissioner and host commissioning body after PSM approval by the site management team

Send form to: PSIRF@Elysiumhealthcare.co.uk

Save form as: P1-UNITNAME-IRISINCIDENTNUMBER-00.00.0000 (e.g.: P1-COPSE-IR987654-25.02.2025)

Service / Unit / Hospital	
Ward Name	
Security Level	
IRIS Incident Number	
Patient NHS Number & Elysium Identifier	
Patient Initials	
Patient DOB	
Gender	
Ethnicity	
Diagnosis	
Responsible Clinician	
Responsible ICB/LA for Patient	
Legal Status (MHA/MCA or None)	
Date of Incident	
Time of Incident	
Location of Incident	

Escalation Reasons	**Criteria to Escalate: Options** – mark all applicable with X	**Mark X Below**
IRIS RISK SCORE [ ] All incidents either meeting the criteria to escalate **and / or** are graded level 3+ must be sent to the	Any safety incident that has required the individual to be escalated to general hospital	
	Any safety incident that potentially there will be staff disciplinary action	
	Any safety incident that the police are asked to respond to and/or a 999 call made to emergency services	
	Missing service user	
	AWOL (Detained patient)	
	Escape from within service and absconding from escorts	
	Failure to return from leave	
	Any safeguarding incident going to a Section 42 England; Section 126 Wales; Section 47 Children.	
	Any incident that triggers Duty of Candour	

Patient Safety Meeting	Mental Health Act breach leading to illegal detention	
	Any incident that compromises the safety of the unit	
	Any incident that has media interest	
	All deaths	
	All significant incidents that are not included in the above where the service, region, network, or the board chooses to escalate	

Brief description what happened (including dates / times) **100 words only**. If relevant, please confirm prescribed observation level at time of incident. The IRIS report will be available to the PSM no need to repeat	

Other Notifications – Mark Yes or No only	**Y/N**
Police involved / informed	
Coroner involved / informed	
Known press / media involvement - alert the communications team and then forward the P1 form to marketing / communications when approved by PSM	
Next of kin informed	
Safeguarding procedures implemented	
Are HR Actions being undertaken with any staff member	

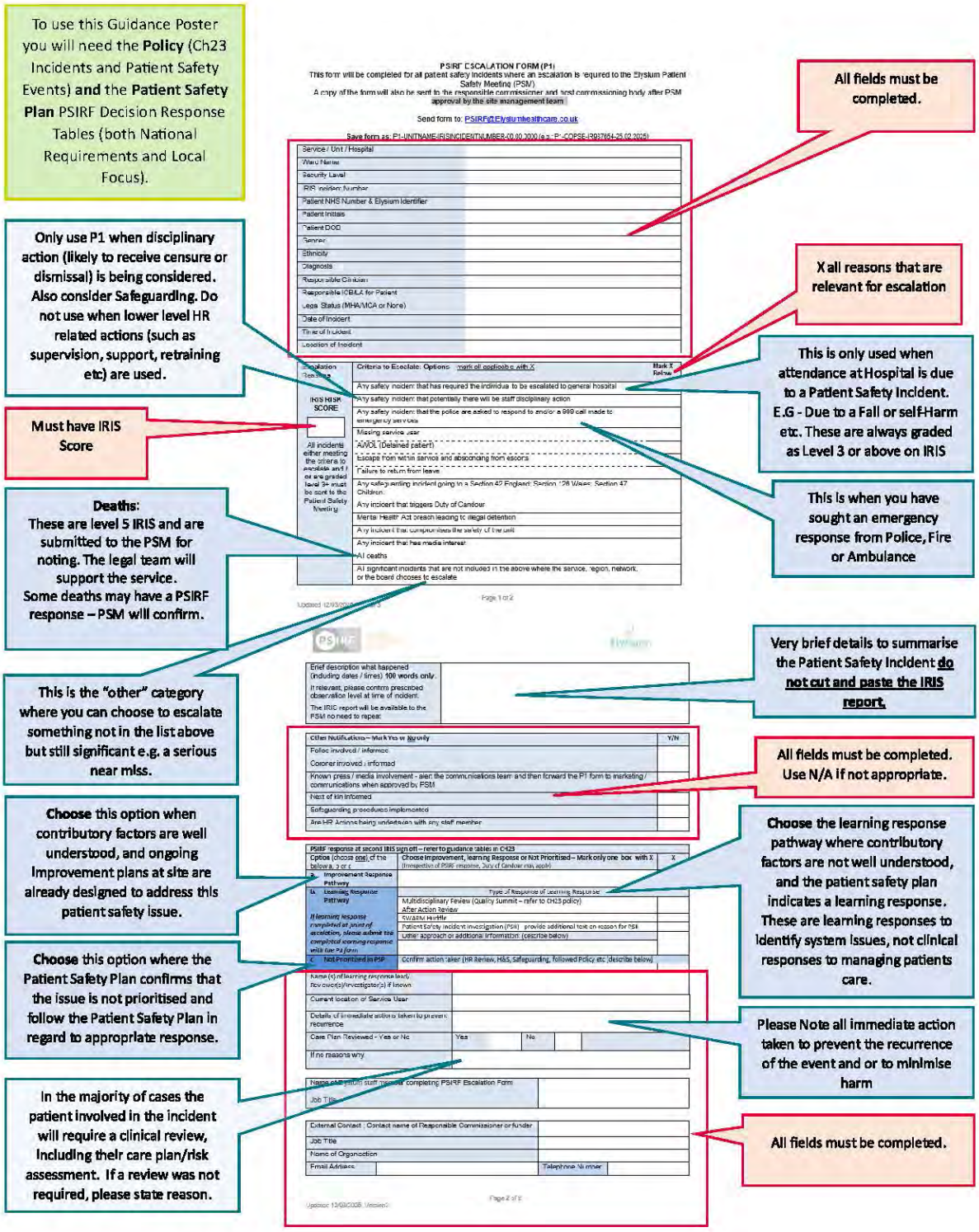
PSIRF response at second IRIS sign off – refer to guidance tables in CH23		
Option (choose **one**) of the below a, b or c	**Choose Improvement, learning Response or Not Prioritised – Mark only one box with X** (Irrespective of PSIRF response, Duty of Candour may apply)	**X**
a. Improvement Response Pathway		
b. Learning Response Pathway ***If learning response completed at point of escalation, please submit the completed learning response with the P1 form***	Type of Response of Learning Response	
	Multidisciplinary Review (Quality Summit – refer to CH23 policy)	
	After Action Review	
	SWARM Huddle	
	Patient Safety Incident Investigation (PSII) - provide additional text on reason for PSII	
	Other approach or additional information: (describe below)	
c. Not Prioritised in PSP	Confirm action taken (HR Review, H&S, Safeguarding, followed Policy etc (describe below)	

Name (s) of learning response lead/ Reviewer(s)/Investigator(s) if known					
Current location of Service User					
Details of immediate actions taken to prevent recurrence					
Care Plan Reviewed - Yes or No	Yes		No		
If no reasons why					

Name of Elysium staff member completing PSIRF Escalation Form	
Job Title	

External Contact ; Contact name of Responsible Commissioner or funder			
Job Title			
Name of Organisation			
Email Address		Telephone Number	

PSIRF P1 FORM GUIDANCE (12.03.2025)



Appendix 02

The PSIRF Delayed Discharge and Notice Served Form

This form will be completed for all patients who meet the criteria for delayed discharge or the commissioning contracting body has been given notice where action to move patient is with the commissioning body. Sites will notify the contracting team of all patients who fall within this definition. The form is completed by the Contracting Team and sent to the Elysium Patient Safety Meeting (PSM)
A copy of the form will also be sent to the responsible commissioner and host commissioning body after PSM approval by the Contracting Team

Send form to: PSIRF@Elysiumhealthcare.co.uk
Save form as: P2-UNITNAME-ElysiumIdentifier-00.00.0000 (e.g.: P2-COPSE-15-99-85-25.12.2022)

Service / Unit / Hospital	
Ward Name	
Date of Admission	
Patient NHS Number & Elysium identifier	
Patient Initials	
Patient DOB	
Gender	
Ethnicity	
Responsible ICB/PC/LA for Patient	
MHA Status	
Date of notification	
Brief description of communication to commissioner to date	

Notification Reason	**Options**– mark with X all applicable	**Mark with X Below**
Care notes must also state that the person is a delayed discharge.	Delayed Discharge	
	Notice Served as service user escalating beyond the management capacity of the service and therefore causing safety concerns	

Patient Safety – for the individual and others	
Interim safety Management plan	
Name of staff member completing PSIRF P2 Form	
Job Title	
Contact name for Responsible Commissioners contacted	
Job Title	
Name of Organisation	
Email Address	
Telephone Number	

Appendix 03

PSIRF BOARD ESCALATION FORM

This form will be completed by the Elysium Patient Safety Meeting (PSM) for all patient safety incidents where an escalation is required to the Executive Team and Quality and Risk Committee

Save form as: **Save form as**: P3-0 – (P1-000) UNITNAME--00.00.0000 (e.g.: P3 -1-(P1-101) COPSE-25.12.2022)

Service / Unit / Hospital	
Ward Name	
IRIS Incident Number	
Elysium Identifier	
Date of Incident	
Time of Incident	
Location of Incident	

Escalation	**Brief description why escalating**
IRIS RISK SCORE	
	Actions recommended to service by PSM:
	P1 form and IRIS summary attachments

Additional Issues or any other relevant matters

Police involved / informed	
Coroner involved / informed	
Known press / media involvement	
Safeguarding procedures implemented	

Name of staff member completing PSIRF Board Escalation Form	
Job Title	

Appendix 04

Patient Safety Meeting Clinical Concern Note

Issue of concern: At the Patient Safety meeting held on 28th May 2025 there was concern raised upon receiving a new P2 (P2.25 00-25) relating to the latest young person who is awaiting transfer of care to adult services within our CAMHs inpatient beds, who has been immediately on their 18th birthday placed on enhanced level 3 1:1 observation as a safeguarding measure. This is solely due to reaching their birthday and therefore technically becoming an adult in a children's service. The placement on observation is a blanket restriction and not assessed either to meet the individual's or other young people's needs and based solely on interpretation of commissioner expectations, as a safeguarding measure.

There have been numerous P2 reports of delay in transfers of care at the age of 18 and young people being placed de facto on formal observation levels to manage safeguarding.

PSIRF	Site	Funder	Date Notified	P2 Reason	Date Closed
P2.25 00-25	Emerald Place Clinic	Surrey Heartlands - CAMHS (PC)	23/05/2025	18+ at CAMHS Site	
P2.25 00-23	Emerald Place Clinic	Surrey Heartlands - CAMHS (PC)	28/04/2025	18+ at CAMHS Site	30/04/2025
P2.25 00-20	Potters Bar CAMHS	East of England - CAMHS (PC)	09/04/2025	18+ at CAMHS Site	22/04/2025
P2.25 00-17	Potters Bar CAMHS	East of England - CAMHS (PC)	28/03/2025	18+ at CAMHS Site	
P2.25 00-16	Emerald Place Clinic	Surrey Heartlands - CAMHS (PC)	27/03/2025	18+ at CAMHS Site	28/03/2025
P2.25 00-09	Potters Bar CAMHS	Jersey Health and S S	28/02/2025	18+ at CAMHS Site	03/03/2025
P2.25 00-07	Potters Bar CAMHS	East of England - CAMHS (PC)	21/02/2025	18+ at CAMHS Site	03/03/2025
P2.24 00-60	Potters Bar CAMHS	East of England - CAMHS (PC)	14/11/2024	18+ at CAMHS Site	19/11/2024
P2.24 00-36	Potters Bar CAMHS	East of England - CAMHS (PC)	17/07/2024	18+ at CAMHS Site	31/07/2024
P2.24 00-24	Rhodes Wood Hospital	East of England - CAMHS (PC)	23/05/2024	18+ at CAMHS Site	28/05/2024
P2.24 00-04	Brighton + Hove CAMHS	Wessex - CAMHS (PC)	19/01/2024	18+ at CAMHS Site	01/02/2024
P2.24 00-03	Rhodes Wood Hospital	East of England - CAMHS (PC)	10/01/2024	18+ at CAMHS Site	09/01/2024
P2.24 00-01	Potters Bar CAMHS	East of England - CAMHS (PC)	21/12/2023	18+ at CAMHS Site	21/03/2024
PSIRF 496	Potters Bar CAMHS	East of England - CAMHS (PC)	17/12/2023	18+ at CAMHS Site	08/01/2024
PSIRF 094	Rhodes Wood Hospital	Hampshire, Sussex and Kent SMH (PC)	28/09/2023	18+ at CAMHS Site	07/11/2023
PSIRF 019	Brighton + Hove CAMHS	Hampshire, Sussex and Kent SMH (PC)	13/09/2023	18+ at CAMHS Site	10/10/2023
PSIRF 018	Brighton + Hove CAMHS	Hampshire, Sussex and Kent SMH (PC)	13/09/2023	18+ at CAMHS Site	21/11/2023
PSIRF 009	Rhodes Wood Hospital	East Midlands - CAMHS (PC)	17/06/2023	18+ at CAMHS Site	07/11/2023
PSIRF 008	Rhodes Wood Hospital	Hampshire, Sussex and Kent SMH (PC)	08/09/2023	18+ at CAMHS Site	09/10/2023
P2.25 00-08	Emerald Place Clinic	Surrey Heartlands - CAMHS (PC)	26/02/2025	18+ at CAMHS Site	14/03/2025

Since we commenced PSIRF and the P2 process (September 2023) there have been 20 episodes reported to the PSM through a P2 of young people delayed discharge at the age of 18 with the longest delay being 143 days and the average delay being 28 days. All these young people were placed on enhanced level 3 observations from the information provided on the P2 form. It would appear that in all cases this was a blanket decision rather than an individually assessed prescription of observation required for an identified clinical risk.

The discussion at the PSM. There is a general view that we continue placing young people on observations on their 18th birthday and that this is a practice that is not meeting any assessed need

and of more concern that the sudden change in the clinical management of the young people maybe causing distress or harm.

Recommendation:

- The issue of placing CAMHS patients on automatic enhanced observation on their 18th birthday should be reviewed post the HSSIB (report below). This review should be undertaken by the CAMHS Network with support from the reducing restrictive practice group, to establish best practice in the management of any assessed risk during transition. Recognising that points of transition do have clinical risk and planning should commence at least 6 months before the individuals 18th birthday.
- Noting the national change in requirement to remain in education meaning that these 18 year old young people would still be at school.
- Invite NHSE commissioners / Provider Collaboratives to be part of our clinical network review of practice based upon clinical assessment of risk and the findings in HSSIB report to remove blanket restrictive practice.
- Outcome of above should be notified to the commissioners of our CAMHs services through the normal contract negotiations process.

HSSIB Report: Supporting Safe care during transitions from inpatient CAMHS to adult services

"2.4.8 In summary, the investigation learned that the approach to safeguarding across providers was inconsistent for young people who turned 18 in inpatient CYPMHS. Some applied blanket approaches when young people reached 18, while others based mitigation measures on individual behaviours and risks with no overnight change in approach. Where blanket mitigation measures were implemented, safeguarding was often considered a key driver for age-based transitions"

Mental health inpatient settings: Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services

Jo Scott

Group Director Quality Assurance

29.05.2025

Patient Safety Meeting Clinical Concern Note (3) Ward/Service Gardens

1. **Issue of concern**: Frequency of Patient Safety Events (PSE) occurring in ward/service gardens

   At the Patient Safety meeting held on 13th August 2025 the members discussed the persistent rate of incidents that occur in ward/service gardens.

   There is a tension between access to fresh air and managing the risk of a PSE within ward/service gardens. Regulators are concerned when there is undue restriction to fresh air, similarly the harm that results from poorly managed access to the garden/outside spaces is of concern. Access to fresh air is a basic human right and must feature as part of all patients care and treatment. Our patients' risks are unique to the individual but in most cases, and specifically when they are detained, that will include a risk to self and or others when in garden areas. These risks should never be assumed to be lower just because they are in the garden and maintenance of effective observation will be required in all areas of the ward/service.

   There are various themes that group around the following main elements

   - Escape from the garden
   - Violence and Aggression
   - Contraband
   - Self-Harm

   A common occurrence within all events is no observation, reduced observation or observation failure/issues alongside other issues with garden design and environmental risk. Observation failure has been whole or part of the safety event for 38 of 54 P1 reports

Factors	Total	Escalation Reason for P1	Total
Garden Design	28	Security	40
Climb Points	34	Health /Fall/Self Harm	10
Not Observed in garden	24	Violence and Aggression	4
Observation issues	14	**Note**	
Safe Practice concern	1	It is no surprise that data relating to garden patient safety events, which are mostly related to escape identify the key factors that aid escape (design and climb points)	
Access to weapon	1		
System failure	1		
TOTAL (more than one per P1)	**103**		

2. **P1 Incidents 2024/25 to date.**

P1 No	Site	Incident Date	Escalation Factors	Summary from IRIS/P1
P1.24 00-76	The Limes	12/01/2024	Security **Not Observed in the Garden**	Patient jumped over the fence at and escaping from the service.
P1.24 01-31	Chadwick Lodge	22/01/2024	Security **Garden Design** **Climb Points**	Patient proceeded to the garden, where he climbed the fence and onto the ward roof. The response team surrounded the potential exit points, verbally de-escalating Police and Fire Brigade. Patient eventually climbed down the wall and was supported by staff.
P1.24 03-63	Ann House	24/02/2024	Security **Not Observed in the Garden**	Patient escaped from building by climbing over the fence in one of the gardens. Walked up to railway tracks and was spotted by a member of the public who informed police. Returned to service
P1.24 03-87	Ty Grosvenor	06/03/2024	Security **Garden Design** **Climb Points**	Patients were in the garden, with staff member observing. Patent was seen trying to climb over fence, further staff alerted, and patient managed to get over the fence.

				Staff went out through front doors of hospital and located patient who initially refused to return to the ward. Following verbal de-escalation patient returned to the ward.
P1.24 03-89	Barnet Lane Clinic	04/03/2024	Self-Harm **Garden Design Observation**	Patient was followed into the garden by Mental Health Support Worker and was seen going to the dark corner of the garden where it appeared like she was searching for something. Mental Health Support Worker asked her what she was doing in the garden, and she reported to staff that she had taken an overdose of Paracetamol, stated that she had kept the tablets in the garden.
P1.24 04-28	Farmfield Hospital	11/03/2024	Health **Garden Design Observation**	Staff conducting random urine drug screening and patient tested positive for Cocaine, he reported that another service user gave it to him. Service user 2 had his ward round and reported someone drop it off by the secure garden gates for him.
P1.24 07-38	The Spinney	27/04/2024	Security **Garden Design Climb Points**	Patient was utilising grounds leave escorted by two staff. He was sat at the drop-in centre within the hospital grounds and then ran from staff towards the gates. Patient managed to access local community (approximately 400m from Hospital). He was then brought back using hospital vehicle with support from responding staff.
P1.24 08-04	Ann House	11/05/2024	Security **Garden Design Climb Points**	Patient jumped over the side fence at Ann House and walked around the front where staff met him
P1.24 08-40	Emerald Place Clinic	18/05/2024	Security **Garden Design Climb Points**	Multiple Patients accessed the roof by climbing onto window ledges and moving furniture
P1.24 08-62	Emerald Place Clinic	19/05/2024	Fall **Garden Design Climb Points**	Young person was in the garden area outside the dining room, engaging with peers. All peers were elated in mood and repeatedly attempting to climb on furniture and the windowsill. Staff attempted to de-escalate the situation this when patient attempted to climb on the windowsill, appeared to lose footing and fell landing on her left arm.
P1.24 08-67	Thornford Park	21/05/2024	Health - Fall **Garden Design Climb Points**	Patient observed in in the ward garden and managed to climb over the ward fence. Response team went into the grounds and Patient ran away, climbed over another fence near Donnington Ward into a non-patient area and managed to climb onto the roof of Donnington ward Patient ran and jumped from the ward roof and landed on the floor. A response team with emergency bags were already close by as he had been indicating he was going to jump. Ambulance attended an took to Hospital. Admitted to John Radcliffe Hospital; fracture.
P1.24 09-53	The Chimneys	05/06/2024	Self Harm **Garden Design Observation**	Patient on Level 4 2:1 observation disclosed to one of the ward staff that they had swallowed a part of a vape. The staff member went to investigate this and saw one of the cartridges was missing. CCTV reviewed and evidenced they had swallowed it, this by secreting and swallowing on return to the ward from the garden. It appears patient removed this whilst in the garden using her blanket to secrete this from staff.
P1.24 09-65	Pinhoe View	06/06/2024	Security **Not Observed in the Garden**	4 patients were utilising the ward garden and were kicking/throwing rugby ball around and kicking the punch bag. Staff came and completed observation checks at 20:10. Following this, 2 patients were visibly seen on CCTV looking at the fence line and making gestures to support a patient over the fence. 1 patient was trying to climb the drainpipe and use the ward door as leverage, then the patient tried the service hatch within the fence line which he managed to open and proceeded to exit perimeter.
P1.24 09-85	Clipstone House	07/06/2024	Violence and aggression **Garden Design Observation**	Patient calmly entered the garden space and quickly climbed onto the fence and pulled himself up on to the main house roof. The alarm was pulled but did not activate. Patient began punching the tiles and broke several of them which caused injury to his fingers and knuckles. Staff responded and verbally de-escalated and after a short period of time patient climbed down

P1.24 11-96	Ty Grosvenor	17/07/2024	Health - Fall **Garden Design Climb Points Observation**	At 10:20 patient took chair from dining room to Brenig garden, he then utilised it to climb over the fence he fell the other side onto his ankles and could not mobilise. Ambulance called and took patient to general hospital whereby they discovered he had broken both ankles and put into plaster.
P1.24 12-09	Cefn Carnau	22/07/2024	Self Harm **Not Observed in the Garden**	Patient requested to use the ward handheld phone. A staff member gave the phone. Patient was not supervised after being given the phone. Patient took the phone out to the garden and ingested 2 AAA batteries, returned to the ward and informed staff of actions.
P1.24 12-82	Aberbeeg	01/08/2024	Violence and aggression **Garden Design**	As patient 1 was walking up the garden steps, patient 2 attempted to punch patient 1 however his punch did not connect. Patient 2 was observed by HCW CT pushing patient 1 and 1 fell down the steps hitting his face on the concrete.
P1.24 13-07	Kingswood House	01/08/2024	Security **Safe Practice Issue Observation**	Patient requested to go into the garden, where the maintenance worker was mowing the lawn. approached it on more than one occasion. Whilst Patient was at the other end of the garden, the maintenance worker thought he should vacate the area with his lawn mower, and he proceeded to do so. He opened the gate and attempted to get the lawn mower out quickly, however Patient ran down the path towards the gate and pushed himself through as the maintenance was trying to close it.
P1.24 13-09	Pinhoe View	05/08/2024	Security **Garden Design Climb Points Observation**	Patient requested to go out into garden. This was permitted in company of staff member and peer. Patient had previously tried to scale fence two days previously Staff member was talking to peer, then staff noted Patient climbing the fence. Staff pulled their alarm and requested peer to return inside. Staff tried to stop Patient but Patient managed to climb the fence and jump over.
P1.24 13-75	Field House	20/08/2024	Security **Garden Design Climb Points Observation**	Patient was on intermittent checks (level 2 x 4), staff were carrying out checks and were unable to locate him. His last known location was in the garden in the smoking shelter. He was reported AWOL Patient was returned to the service at 0450hrs, the police raised concerns regarding the treatment of Patient due to this being a second time of a similar incident in a short space of time. Due to jumping over the fence, Patient sprained his ankle and was supported to access general hospital with the police prior to returning to the service.
P1.24 15-14	Field House	13/09/2024	Self Harm **Not Observed in the Garden**	Informal service user on level 2 X 4 checks in the hour. Patient had threatened to self-harm and continuously presented as risk. The NIC authorised bedroom to be locked for safety purposes. Patient requested to use the garden to smoke. As she got back from the garden, patient reported to staff that, she has ingested batteries
P1.24 15-16	Sturt House	14/09/2024	Security **Not Observed in the Garden**	Staff completing the observation checks approached the Nurse in charge to advise that he could not locate Patient in the building. All staff searched the building however patient could not be located. CCTV was checked by security lead, and it was observed that at 10:13hrs, had jumped over the garden gate fence. The observation records were compared to CCTV by the Nurse in charge, and it was observed that Patient had jumped over the garden gate fence at 10:13hrs
P1.24 15-22	Ty Grosvenor	16/09/2024	Security **Not Observed in the Garden**	Patient was in Alwen garden, he managed to climb the fence and leave the hospital grounds. He was gone for 7 minutes. Staff identified that he was missing and commenced the search. While staff searched the grounds, the patient returned over the fence.
P1.24 15-31	Ty Grosvenor	17/09/2024	Security **Garden Design Climb Points**	Patient was in garden; he managed to climb the fence and leave the hospital grounds despite staff members in the garden attempting to stop this. Staff commenced the search of the local area and police informed.
P1.24 15-38	Thornford Park	02/09/2024	Security **Not Observed in the Garden**	Patient was on 1:1 observation. Patient managed to climb the fence of the ward garden. He was in located in the grounds by police (who were on site dealing with

			Garden Design **Climb Points**	another incident) as they arrived. Patient was handcuffed by the police, and returned to the ward
P1.24 15-39	Thornford Park	02/09/2024	Violence and Aggression **Observation** **Garden Design** **Climb Points**	Patient 1 jumped over the fence from Headley ward garden and broke wood from the fence from Kingsclere garden. He approached reception area and started hitting the door and threatening staff. Patient 2 was assisted over the fence from Adbury ward and joined patient 1 by the reception area of the hospital within the secure perimeter.
P1.24 15-65	Ty Grosvenor	18/09/2024	Security **Garden Design** **Climb Points**	Patient escorted in garden with Bank and jumped the gate. AWOL
P1.24 17-56	Pinhoe View	25/10/2024	Security **Not Observed in the Garden** **Garden Design** **Climb Points**	A tool bag was being used to contain all the tools that they may have needed, and when they had finished the activity, the OTA picked up both kneeling pads, and put them in the bag, and the patient and OTA returned to the ward. The OTA did not notice that a kneeling mat had fallen out of the bag while still in the garden, and there was no system for logging items in use or returned items which would have highlighted the loss of the kneeling pad. On review of CCTV following up from the escape of the patient, staff noted that the patient had noticed the kneeing pad in the garden at 12:52 hours. The patient was seen on CCTV to retrieve the pad and use it by jamming it in between the fence posts and use it as an aid to climb up and over the garden fence and leave the hospital grounds. The patient was noted as missing during observation at 13:05, and staff searched the ward with no success in finding the patient.
P1.24 18-08	Pinhoe View	30/10/2024	Security **Not Observed in the Garden** **Garden Design** **Climb Points**	The patient went out into the ward garden with a peer for fresh air. Approximately 10 minutes later staff noted that the patient was not in the garden. Staff checked the ward and patient was not found. Staff spoke to peer, and peer told staff that they had assisted patient to scale over the garden fence. Staff checked the hospital grounds and surrounding areas, but the patient was not found. Staff implemented AWOL procedures and reported the AWOL patient to on-call manager, and to police.
P1.24 18-44	Three Valleys Hospital	09/11/2024	Security **Not Observed in the Garden**	Patient had been granted unescorted garden leave in his MDT on Friday 08/11/2024. On Saturday 09/11/2024 just before 14. 00hrs Patient was let into the ward garden to smoke as part of his unescorted leave. At 14.13hrs it was noted that patient was missing. Patient is on general observations.
P1.24 18-64	Chadwick Lodge	12/11/2024	Security **Not Observed in the Garden** **Garden Design**	Patient was seen entering the Isla Garden. A few minutes later staff went to the garden and could not see Patient there. A ward search was conducted to ensure that Patient had not come back inside however a search was also started in the local area. CTV and showed that patient absconded via the roof at 10:17.
P1.24 20-35	Sturt House	02/09/2024	Security **Garden Design** **Climb Points**	Patient became very agitated and hostile and proceeded to go to the ground floor corridor where he was observed to pull the ward payphone of the wall. Staff pulled their alarms and multiple staff members attended Staff suggested that it may be productive to open the enclosed garden door as accessing fresh air has helped him manage his anxiety previously. When staff opened the door, Patient was observed to run towards the fence, and then climb over the fence.
P1.24 20-83	Thornford Park	19/10/2024	Aggression and violence **Access to garden with weapon**	Patient acquired scissors from his hair clippers set that he requested from security and was threatening staff with same. Response summoned and patient entered the ward garden. Verbal de-escalation and negotiations were unsuccessful. The police were called and 8 officer arrived and negotiated with the patient. Patient threw the scissors on the floor and police restrained patient and moved him to seclusion.
P1.25 04-13	The Limes	03/03/2025	Security **Garden Design**	At 10:00hrs of the 03/03/2025, patient went out in the hospital garden to smoke a cigarette, he was initially

			Climb Points	stood on the grass before walking over the decking area where he proceeded to use the decking as a ladder to climb over the fence and escape from the hospital grounds.
P1.25 04-26	Ty Grosvenor	04/03/2025	Security **Observation** **Garden Design** **Climb Points**	Patient climbed over the fence in the ward garden and gone AWOL
P1.25 05-41	Three Valleys Hospital	21/03/2025	Security **Observation** **Garden Design** **Climb Points**	Patient was placed on escorted garden leave only. At 17.30 pm patient used the Oldfield Garden to smoke with escort and absconded from the garden by scaling the fence.
P1.25 05-63	The Chimneys	08/03/2025	Security **Garden Design** **Climb Points** **System failure**	patient being nursed on level 3 1:1 observation at the time of the incident. Garden access had been suspended the previous afternoon following expressing intent to abscond by jumping over the garden fence. Patient was in the ward garden escorted by a health care assistant. Patient suddenly began climbing up the fence. Staff pulled their alarm; however, this did not work due being out of range. They then called for assistance on their radio; however, this also did not work. Another health care assistant who was sat in the lounge on another patient's observation, saw Patient attempting to jump over the fence and used their radio to call for assistance to the car park. Patient returned to ward
P1.25 05-90	Barnet Lane Clinic	30/03/2025	Security **Observation** **Climb Points**	CCTV review Patient was observed climbing the fence using the benched he positioned to escape from the ward.
P1.25 06-17	Chadwick Lodge	29/03/2025	Security **Observation** **Climb Points**	Member of staff opened the door to patient access to the garden. The member of staff went to dispose of the rubbish he had left at the kitchen hatch and upon returning he noticed that Patient was not in the garden when he checked on him. Patient had scaled the wall and fence from the garden courtyard absconding from the unit.
P1.25 06-18	Aberbeeg	27/03/2025	Security **Observation** **Garden Design**	Patient obtained the illicit drugs thrown over into the secure garden
P1.25 07-58	Three Valleys Hospital	21/04/2025	Security **Not Observed in the Garden** **Climb Points**	A patient reported to staff that another patient had jumped over the fence in the garden
P1.25 07-89	Woodmill	21/04/2025	Security **Not Observed in the Garden** **Climb Points**	Footprints noted in mud it was thought and later confirmed on CCTV that the patient escaped when in Rose Garden. Climbed the fence , hid behind cars in car park and then ran off site
P1.25 07-98	Three Valleys Hospital	24/04/2025	Security **Not Observed in the Garden** **Climb Points**	Patient followed another patient into the garden and jumped over the fence
P1.25 08-36	Dunnock View	02/05/2025	Security **Not Observed in the Garden** **Climb Points**	A CCTV footage revealed that Patient had escaped the ward by going over the roof and jumping over the fence whiles in the enclosed garden using the garden furniture to aid his escape. A search was carried out within and outside the hospital premises
P1.25 09-11	Three Valleys Hospital	17/05/2025	Security **Climb Points**	Patient was being escorted to smoke in the garden. He jumped over the fence at 11.22. Staff initiated a search of the grounds and local area,
P1.25 11-90	Pinhoe View	04/07/2025	Security **Not Observed in the Garden** **Climb Points**	CTV indicated, he was in the garden (which is unsupervised access) with his peers. At around 21:31hrs he walks towards the right-hand corner of the garden, where the secure fence and building connects and laid down a rolled-up yoga mat and climbs up the building wall on to the fence line and jumps down. He noticeably used gloves to aid him climbing the building wall. He then walks off through the bushes on to the main road.

				There was no evidence of risk relating to AWOL or absconding prior to this incident.
P1.25 12-21	Chadwick Lodge	22/10/2025	Security **Not Observed in the Garden** **Climb Points**	Healthcare Assistant checked Patient bedroom, and the ward courtyard garden and Patient was not there. The Healthcare Assistant notified the Charge Nurse who and noted that Patient had scaled the fence and not on the ward
P1.25 12-23	Chadwick Lodge	07/07/2025	Security **Not Observed in the Garden** **Climb Points**	Patient jumped over Isla courtyard garden fence with intent to go to A & E for assessment and treatment. Patient was still on the roof where staff reassured and supported him to come off the roof.
P1.25 12-75	Three Valleys Hospital	15/07/2025	Security **Not Observed in the Garden** **Climb Points**	Patient was sighted leaving the hospital grounds having jumped over the fence by a staff member who was off site during a rest break at 16.30
P1.25 12-83	Three Valleys Hospital	20/07/2025	Security **Not Observed in the Garden** **Climb Points**	Nurse in charge was informed by a patient that another had climbed over the fence in Oldfield Garden, having gained egress via the door leading to the garden
P1.25 12-84	Field House	20/07/2025	Self-Harm **Not Observed in the Garden**	Unobserved or unsupervised access to garden and self -Harm
P1.25 13-94	Ty Grosvenor	01/08/2025	Security **Not Observed in the Garden** **Climb Points**	Patient has escaped from the ward Has managed to climb one of the trees in the garden and get on to the top of the ward fence from there on checking the CCTV
P1.25 13-97	Chadwick Lodge	29/07/2025	Self-Harm **Not Observed in the Garden**	Patient was on 4 random checks per hour intermittent observations at the time of the incident. Patient ingested a piece of wood whilst in the garden

3. **Review of Data.** Since we commenced PSIRF database (December 2023 – End July 2025) there have been 54 episodes of patient safety events in garden areas reported to the Patient Safety Meeting (PSM) through a P1. Other events occurred in gardens where location was not a significant contribution to the event or may not have reached the escalation threshold for the PSM and will have been managed locally.

   Observation failure or no observation was the most reported factor for 38 of 54 events. The reason for low or no observation includes:

   - Staffing ladders not designed to staff the garden when door open
   - Ward has no planned staffing in the garden when open.
   - Staff not realising risk that can occur in non-observed spaces.
   - Poor environmental management (door left open or unsecured furniture in secure services)
   - Maintaining general observation but not matching that to increased risk of PSE in the garden area. This would be similar to not having staff presence in a communal area.

   It is often reported that the furniture or fence height in non-secure services was the cause of an escape/PSE when in fact there was no observation of the garden occurring. Observational effect will limit opportunistic escape or other PSE.

   The issue of effective observation and environmental design in secure gardens has been raised through audit and compliance to national standards. It should be noted that outside of these services there is no consistent national standard.

Patients without community leave should be able to access ward gardens, but the risk of a PSE should ensure that observation of this area is part of normal routine to ensure reduction in any risk of PSE.

4. **The discussion at the PSM.**

Access to the garden of a ward/service must be seen as a normal activity of daily life, and part of the service's daily routine. Good design and ease of access/location of the garden aid accessibility and reduce risk, but not all services have gardens that are in accessible areas, and there are different needs across Elysium for the use of a ward/service garden. This should be reflected in safe staffing numbers.

There is a known risk of a patient safety event occurring, especially where detained patients may seek to leave the service, but this is ameliorated by good design and observation.

Procedures and practice in relation to managing gardens must include the assessment of the environment and a risk profile to match the known and anticipated risks of the service population and or individual patients, e.g. a secure service must comply to national standards on fence height and equipment/observation, irrespective of individual risk. Care home gardens with steps should be noted for patients with assessed mobility issues etc.

5. **Recommendation:**

Procedures and practice in relation to managing gardens must include:

- the assessment of the garden, its risks and areas that require special attention (blind spots, stairs etc) these should form part of the ward/service risk profile and amelioration and action taken to reduce risk as far as possible.
- risk profile of the gardens environmental risk should match to the known and anticipated risks of the service population as a whole and individual risk profiles
- environmental checks of the garden must be risk based with a wider scrutiny of environment for health and safety and compliance to any standards.
- All items purchased for use in gardens must be chosen to meet the known and assessable PSE risk in the ward/service garden
- gardens, with identifiable or known absconding risk, that are used by detained or vulnerable patients or accessed by individuals with absconding risk should always be considered observed spaces.
- gardens in all secure services are always observed and controlled spaces.
- in all cases the garden, when in use, should be seen as an extension of the ward/service day space and requires staff management/observation.

Jo Scott

Group Director Quality Assurance

25.08.2025

PSIRF Safety Bulletin – September 2025 (Issue 7)

Patient Safety Events May – August 2025

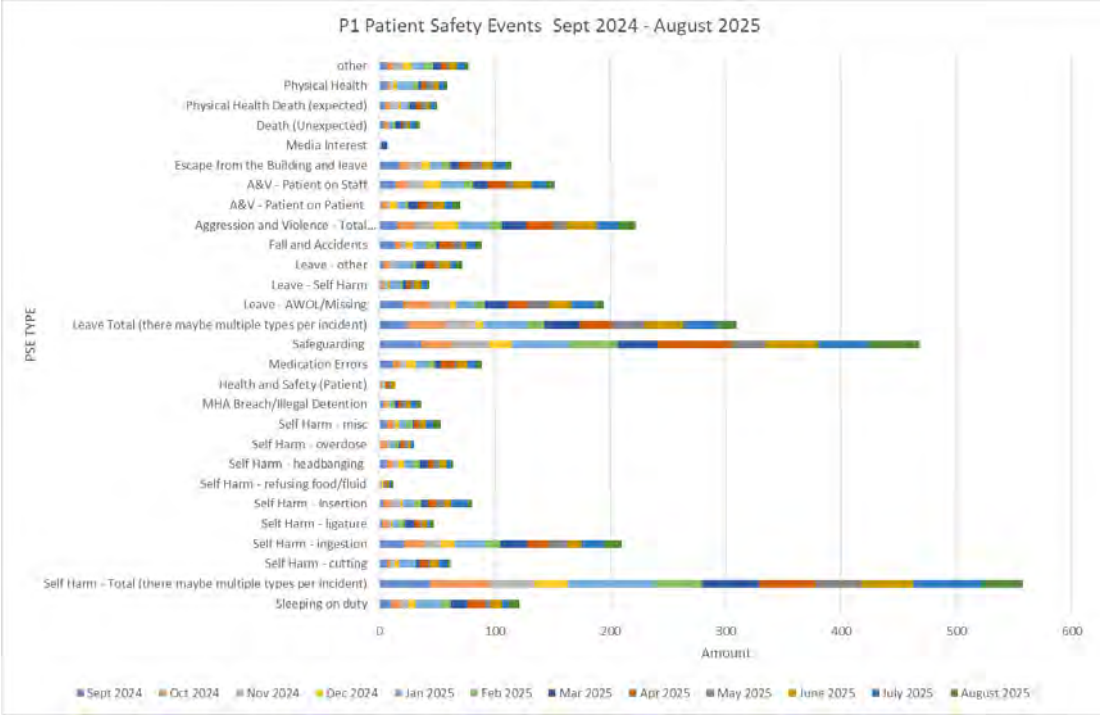
1. General introduction

Welcome to the seventh Patient Safety Bulletin. PSIRF has now been in operation for over two years, we have seen PSIRF embed into practice across all our services, and we will continue to hone and improve the patient safety systems to share best practice with all our colleagues.

In this bulletin we share below data and information to help colleagues to be aware of key messages relating to escalated patient safety events, emerging themes or specific risks.

2. Escalated Data - Patient Safety Incidents Raised to PSM with a P1 form.

The Chart shows the range of patient safety themes that have been considered at the Patient Safety Meeting (PSM) via P1 forms.



Self-Harm (24.7%) is the most consistently and frequently escalated patient safety event to the Patient Safety Meeting (PSM). Incidents related to leave and AWOL make up 23.5 % of all P1 reports. We monitor aggression and violence that have escalated on a P1 so that we understand the range of risks at our services. Aggression and violence accounts for 9.75% of P1s and violence towards staff is the majority of incidents. Safeguarding (26%) accounts for a significant amount of PSE reported, this includes sleeping on duty, missed observations, allegations of abuse and neglect.

The majority of the P1 forms submitted to the PSM relate to service user action. This is not unexpected within the services we provide considering the risk to self or others is the major reason for admission within a population who are mostly detained under the Mental Health Act 1983.

Patient safety events related to staff interaction/actions with patients, such as observation, both failures to follow care plans and other related issues such as sleeping on duty, remain constant themes. Medication errors are a minority of P1 escalated with 88 cases in 2024/25, but alongside not following care plans, observation failure and error in providing appropriate care are service improvement focused actions, that can be more directly addressed (with training, improvement plans etc) to support quality improvements.

We will start refreshing the Patient Safety Plan in October 2025 and services and clinical networks will be asked to get involved and work with us to support the plan refresh. This is the easy part, the real work is all of you, our services, staff, service users and teams at individual site level working to develop practice, via their regions and clinical networks to meet the patient safety and quality improvement agenda and enhanced ambitions in our refreshed Patient Safety Plan.

3. PSIRF Registers

The PSIRF registers were introduced in September 2023 as a temporary measure with the intention to revise this manual recording of patient safety events in conjunction with the Information Management project to be compliant, automatically submitting data, to the new NHS patient safety reporting system Learn from Patient Safety Events (LFPSE). The work to revise IRIS finally concluded that it would not be capable of being compliant with LFPSE, and a new reporting system would be required. IRIS has a chosen replacement that is RADAR and the process to implement RADAR is now subject to a prioritisation process led by IT.

The patient safety team presented an audit to the September CCG, and it was agreed that the use of PSIRF registers can cease. CCG agreed that the Patient Safety Event (PSE) flagging process now in IRIS will be the interim method of identifying a PSE, and that all service senior management teams must ensure that they correctly identify a PSE at the sign off process.

The IRIS data with this correctly identified PSE is already readily available to services to monitor their patient safety profile.

Services should record any learning from PSE with the identified outcomes/actions plans within the service quality improvement plans.

4. Patient safety themes and safety issues.

Below are the themes that have emerged from services P1 submissions to the PSM since issue 6. Services are encouraged to consider these and all previously identified issues, from earlier bulletins, in the context of what safety actions maybe appropriate for their own service provision.

4.1 Good Practice

The Patient Safety Meeting (PSM) seeks to always feed back to services where notable good practice and good staff care has been demonstrated during a patient safety event. We hope that these are fed back to the staff involved directly. The PSM cannot know all events that were well managed, as these must be frequent every day, and we only see what has been reported to us. We would like to encourage all services, when escalating a patient safety event on a P1 to highlight notable areas of good practice. The staff involved should always have been recognised and praised for managing, what are often extremely stressful events. The following events have been noted:

Service	Patient Safety Event	Good practice
Chimneys	Patient admitted with significant physical health care needs	Service quickly identified physical healthcare needs on admission and managed patients care well.
Gateway	Patient ran from escort and attempted to jump from bridge over motorway	Escorting staff member prevented a patient from jumping, summoned assistance successfully preventing harm to patient and public.
Bradley Complex Care	Escorted patient became disturbed and escalated in a supermarket	Escorting staff summoned assistance, containing the risk to the public and the service dispatched a response team. The patient was deescalated and returned to the service.
Wellesley	Patient had purchased paracetamol whist on unescorted leave. They then overdosed.	The service relationship with community supported the shop to inform staff of their concerns. The staff engagement on the patients return allowed the patient to inform staff of their actions.
Ty Grosvenor	Serious event of violence related to a patient who was AWOL and threats to harm self, staff and Police	The staff managed the AWOL, escalating abuse/violence, and threats to self and others. Maintaining good communication with the patient de-escalation and liaison with police.
Chadwick Lodge	Whist attempting to attack staff a patient accidentally fell and become seriously unwell	Staff responding to a patient who was initially attempting to attack them, quickly responded to a sudden medical emergency. Supporting the patient with ILS and transferred them to A&E.
Gateway	Patient self-harmed with a suspended ligature.	Staff unable to enter a patient's room, raised the alarm and were able to intervene with the suspended ligature to prevent harm.
Potters Bar	Patient was anxious about community leave, ran into the road and cut themselves	Staff immediately responded to prevent further harm to patient and harm to public and safely returned service user to Potters Bar.
Victoria Gardens	Patient threated staff with a weapon and broke window to escape and then continued to caused damage to the building	The staff on duty quickly responded and called for police response and managed the incident with no injuries to staff or patients.
Nursery Road	Resident refused to return to the service or leave the general hospital.	Resident was returned to service in a planned and safe way with no harm to resident or staff using appropriate STMVA
The Spinney	Contraband was suspected of being ingested or inserted to be brought into the service	Staff closely monitored the patient and maintained vigilance over any contraband and behavioural changes of the patient and included UDS and observations regarding mental state.
Chadwick Lodge	Patient had unescorted leave. This was a test leave	Staff undertook a spot check to make sure that the patient was following accepted route. The staff had to intervene as the patient was attempting AWOL. Successfully returned to service.
Gateway	Patient was choking in their room. Staff raised alarm	Successful intervention made by the nurse to dislodge food items.
Cotswold Spa	In between random planned observation checks the patient self-harmed.	Staff responded to the noise the patient was making even though a random check had only just occurred. The staff correctly reacted to the episode of self-harm.
Crossley Place	Patient in the community ran from escorting staff and into the road	Staff responded to the risk behaviours of the patient, placed them in STMVA holds and prevented harm to patient, staff and the public.
Gateway	Patient was threatened with violence by another patient to gain a vape.	Patient was being threatened, and staff managed the safety of the ward and prevented harm. Supporting the victim to report to the police and worked with the police to deescalate the risk

5.2 Clinical Issues

- Mechanical Restraints. – Services are reminded that the scope of practice that includes the term mechanical restraints is inclusive of all services, from neurological to secure service. Services are therefore reminded the use of any type of restraint mechanisms ***must*** be care planned and sites must refer to the Policy CH18 Management of Violence and Aggression
  section 5.10 and appendix E.

- Plastic bags and thinking safety - In mental health settings, plastic bags pose a safety risk due to potential ligature and suffocation hazards, particularly for individuals experiencing suicidal thoughts or other forms of self-harm.

This risk was recently highlighted following a reported case whereby an NHS hospital trust, and a staff member, were found guilty of health and safety failings over the death of a young woman in a mental health unit.

> The woman has a history of attempted suicide using plastic or bin bags on 18 occasions, mostly taking them from a same shared toilet. The hospital had previously acknowledged the risk to patients of keeping bin bags on the ward and they were subsequently taken out of patient bedrooms However, despite warnings, they were not removed from the communal toilet. On 7 July 2015, at her 19th attempt, she took her own life using a bin bag taken from the toilet.
> The trust was found guilty of failing to provide mental health in-patient services in such a way as to ensure that persons not in its employment, namely the patients, were not exposed to risks to their health or safety. The staff member was found guilty of failure to take reasonable care for the health and safety of other persons affected by his acts or omissions at work.
> With the potential increase of rubbish bags on site due to recent legislative changes around separation of waste, it is important all staff are vigilant and regularly reminded of the risk posed by leaving plastic and bin bags in areas service users have access to.

  - Staff should ask patients and relatives not to bring plastic bags onto the ward.
  - It is good practice to have paper bags (at the entrance to the ward) as an alternative for patients and relatives to transfer items into.
  - It is recommended to include plastic bags as a restricted item in ward information booklets.
  - It is recommended in the main part of ward/communal areas/bedrooms/bathrooms etc. to have an alternative to placing plastic bags in bins due to safety risk.
  - Small paper bags should be provided for all sanitary products and then placed into the
    bin.
  - Plastic bags should only be used in restricted areas e.g. kitchen and clinical room where there is supervision.

- *Ensure that there is a checking process for all medical equipment*

Medical Devices - Safety. - It is essential that medical devices meet relevant safety and quality standards, and that they are maintained in a safe working condition at all times. Healthcare professionals are personally accountable for their use of medical devices and therefore must ensure that they have appropriate training and assessment of competence before using any device. Before using a medical device, staff must always conduct a visual inspection to ensure it is in good working order, reporting any defects immediately.

Medical devices must only be purchased via approved providers. If in doubt the Procurement Department will be able to assist.

Maintenance. - Equipment must be kept in good working order and in good repair. The frequency of maintenance will depend on the type of equipment and circumstances of use but you must ensure that the performance of equipment does not deteriorate to the extent that people are put at risk. Manufacturer instruction manuals will contain details of maintenance frequency, and these must be adhered to as a minimum. Records of maintenance must be kept.

An inventory of all equipment and maintenance requirements should be kept locally. Safety-critical components must have planned preventative maintenance programmes in place, in accordance with the manufacturer's recommendations.

Calibration. Some equipment (specifically medical devices) will have a requirement to be calibrated. Calibration is the process of ensuring a measuring instrument provides accurate and consistent readings by comparing it to a known standard. This involves verifying and adjusting the instrument's readings to match the standard, ensuring reliable and accurate measurements.

The frequency of calibration depends on the type of equipment, the application, and regulatory requirements. Some equipment may require calibration annually, while others may need it more frequently. The manufacturers manual must always be consulted and a calibration tracker put in place.

- *Methadone prescribing and mandatory training Acute + PICU services (Opioid Management)*

Opiate Dependence Management - This is an hour-long webinar providing best practice approaches on the care and treatment of MH inpatients, who use substances specifically opiates. The course will provide you with an understanding of opiate use disorder and through a case study, provide you with information and some practical skills needed to safely assess and manage patient in opioid intoxication or withdrawal. This course has been designed for nurses and psychiatrists, who both play a key role when managing opiate withdrawals.

The staff should also be familiar with the policy Opiate Dependency- assessment and management. Chap. 91

- *Garden observation*

  There is a tension between access to fresh air and managing the risk of a PSE within ward/service gardens. Regulators are concerned when there is undue restriction to fresh air, similarly the harm that results from poorly managed access to the garden/outside spaces is of concern. Access to fresh air is a basic human right and must feature as part of all patients care and treatment. Our patients' risks are unique to the individual but in most cases, and specifically when they are detained, that will include a risk to self and or others when in garden areas. These risks should never be assumed to be lower just because they are in the

garden and maintenance of effective observation will be required in all areas of the ward/service.

A common occurrence within all patient safety events in gardens is no observation, reduced observation or observation failure/issues alongside other issues with garden design and environmental risk. Observation failure has been whole or part of the safety event for 38 of 54 P1 reports

Procedures and practice in relation to managing gardens must include:

- The assessment of the garden, its risks and areas that require special attention (blind spots, stairs etc) these should form part of the ward/service risk profile and
  amelioration and action taken to reduce risk as far as possible.
- Risk profile of the gardens environmental risk should match to the known and anticipated risks of the service population as a whole and individual risk profiles
- Environmental checks of the garden must be risk based with a wider scrutiny of environment for health and safety and compliance to any standards.

- All items purchased for use in gardens must be chosen to meet the known and assessable PSE risk in the ward/service garden
- gardens, with identifiable or known absconding risk, that are used by detained or vulnerable patients or accessed by individuals with absconding risk should always be considered observed spaces.
- gardens in all secure services are always observed and controlled spaces.
- in all cases the garden, when in use, should be seen as an extension of the ward/service day space and requires staff management/observation.

5.3 Staff Issues

- *Recording a delayed discharge – and why it's a PSE*

Delay in transfer of care for patients who need either a route to the community or access to more specialised service is a known risk to patient safety. The PSM receives notification of delay through a P2 form. The clinical team at the site also enter the delay into the clinical notes. Delay and extended placement in a setting no longer meeting your needs leads to psychological impacts on health that can precipitate a relapse in care or the escalation of behaviours that the service cannot manage. We monitor the rate of delayed transfers of care. It is very rare that the reason for delay is caused by our services, and in most cases reflects the lack of a safe alternative placement. It is a patient safety issue not only for the direct impact of prolonged stay in the wrong environment, but harm can occur when we continue to manage a patient who is waiting for a new placement.

- Services should always initiate a P2 for any delayed discharge or notice served.
- Care Notes or iCare should always be completed for a delay delayed discharge or Notice.

- *Sleeping on duty* – This is often associated with a breach in the observation care plan and it is important that we are managing the risk to patient safety. The flow chart using the Just Culture Tool is in use and will be included in the new observation policy.

5. Have you got any Questions?

Please drop a question into psirf@elsysiumhealthcare.co.uk

September 2025