Human factors analysis of therapeutic and physical health observations at East London Mental Health NHS Foundation Trust (ELFT) – Summary report

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Executive Summary

The report presents the findings of a thematic human factors analysis of therapeutic and physical health observations on adult in-patient acute and PICUs at East London NHS Foundation Trust (ELFT). Dr Jane Carthey was commissioned to carry out a human factors analysis of a sample of twenty-six serious incident investigation reports, and to gather insights into 'work as done' pertaining to observations of mental health in-patients on adult acute and PICUs. 'Work as done' in the context of observations practice in mental health means how staff conduct both therapeutic and physical health observations, and how they adapt and intervene in response to fluctuations, turbulence, and dynamic changes in the work system. Insights into 'work as done' were elicited in a series of workshops conducted with ward and PICU staff at ELFT.

The key findings from the report are:

Thematic analysis of serious incident investigation reports:

The human factors-based deductive thematic analysis of serious incident investigation reports highlights there are complex interactions between tasks, organisation, technology & tools, person, internal environment, and external environment which impact on how observations are conducted.

Overall, the findings show how the task of carrying out observations (therapeutic and physical health) is embedded within a complex work flow on adult in-patient acute wards and PICUs: The quality and completeness of observations is influenced by multiple factors including other microsystems and tasks, for example, handovers, MDT meetings, ward rounds, admissions and discharges and escorted leave. Observations practice is also impacted by task distribution across the team, how observations are reallocated when unexpected events occur, staffing levels, the 'fit' between staff on shift and patient acuity, whether potential task conflicts are anticipated and managed (e.g. holding the emergency response bleep whilst being allocated intermittent observations), team cohesiveness and culture, equipment functionality and availability, and how distractions and interruptions are handled. It is also impacted by dynamic changes on a ward or PICU, for example, staff responding to another incident, or a patient being stepped up to 2:1 observations midway through the shift.

The analysis of past serious incident investigation reports showed that:

- There are disconnects between 'work as prescribed' in policies and procedures relating to observation, rapid tranquilisation, physical health, searches, VTE risk assessment, falls risk assessment, care planning, risk assessment and incident response, and 'work as done.'
- The complexity of the work system under-pinning observations is denoted by multiple types of interactions between tasks, organisation, person, internal environment, technology & tools, and external environment. The complexity of the work system has led to a diverse range of contributory factors to patient safety incidents. This may explain why previous thematic analyses conducted by ELFT has found it difficult to pinpoint common themes across incidents involving the 'falsification of observations.' The complexity of the work system makes it difficult to identify themes. There are a multitude of interactions in a complex work system

for observations. To improve observation practice, we therefore need to redesign the work system. For example, the SEIPS maps, developed as part of the human factors analysis, highlight a general theme around the conceptualisation and design of the task of therapeutic observations: Observation sheets (i.e. the technology & tools) comprise codes which staff complete when carrying out observations to document each patient's whereabouts. This shapes staff behaviour, so observations are not therapeutic engagement with patients. They are a noting down of the patient's whereabouts at a given point in time. Additionally, naming the task, and associated policies, procedures, and artefacts (i.e. the observation sheet) 'observation' shapes staff behaviour in ways that do not foster therapeutic care.

- The human factors analysis of the strength of recommendations in the serious incident investigation reports shows most of the recommendations analysed are what human factors specialists describe as 'weak' person-focused recommendations. Sixty-six per cent of recommendations from the sample of twenty-six serious incident investigation reports were 'weak' person-focused recommendations. Across all twenty-six reports, there were only two 'strong' (system redesign- focused) recommendations. Examples of 'weak' person focused recommendations are, for example, reminding staff to comply with policies and procedures, didactic training which involves reminding staff about policies and procedures or counselling staff about the way to deliver safe patient care, 'conducting an audit or review, or rewriting safety policies and procedures.
- ELFT's profile of 'weak' person-focused recommendations in past serious incident investigation reports is the same as other healthcare organisations' profiles. ELFT is not an outlier. NHS England has acknowledged that investigations conducted under the previous Serious Incident Framework led to 'weak' person-focused recommendations. The limitations with the previous investigation methodology (root cause analysis) prompted the introduction of the Patient Safety Incident Response Framework (PSIRF) by NHS England in 2022.

Workshops with staff working on adult in-patient acute wards and PICUS, which were structured using a tool called the SEIPS Work System Explorer, showed that:

- Ward and PICU staff adapt and trade off the task of carrying out observations with other competing tasks, for example, taking patients on escorted leave, ward rounds, handovers, emergency response, admissions, discharges, following up referrals and hospital appointments, communicating with family members etc.
- Distractions and interruptions occur frequently when carrying out observations, including requests from patients and other team members, resolving equipment functionality and availability problems, admissions to the ward arriving later than scheduled, and ward rounds taking place at short notice. In terms of equipment functionality, staff highlighted issues with BP monitors being broken, pulse oximeters with flat batteries and broken laptops. All these factors create 'turbulence' in the work system, and impact on how observations are carried out and documented.
- Wards with high numbers of admissions (e.g. Globe, Joshua), usually have more patients on intermittent observations because patients are put onto intermittent observations on admission. Staffing levels post-pandemic have not kept pace

with the increasing admissions and flow of patients through wards, and this in turn, impacts workload.

- There are differences in team culture across wards, and within wards, across shifts. Team culture impacts on workload allocation, equitable treatment of bank staff, and the overall atmosphere on the ward.
- ‘Work as done’ varies from ‘work as imagined’ and ‘work as prescribed’ in key policies and procedures like the ELFT Observation Policy and Procedure. Staff shared examples of observation documentation being done at the end of the shift. Staff also shared examples where they had observed colleagues carrying out several intermittent observations being carried out without the staff member taking the observations board/sheet with them. Staff then completed the observations sheet when they returned to the nursing office, sometimes documenting three or four patients observations from memory. This has implications for audits which measure compliance with observations being documented: Audits measure the number of ‘missed observations’ using what is documented on observation sheets as the data source would not identify these types of workarounds.
- In terms of ‘work as done’ versus ‘work as imagined’ and ‘work as prescribed,’ staff described carrying out observations for several hours at a time.
- The QI intervention of board rounding has helped improve the handover of observations and it has clarified roles and responsibilities for carrying out observations. However, sometimes staff make what are called ‘trade off’ decisions: They weigh up the risk of the observations board being used as a weapon by patients on the ward, and do not take it with them when carrying out observations. This also happens with the equipment needed to carry out physical health observations (e.g. blood pressure monitors).
- The QI intervention of zonal observations is impacted by the composition of the team working on a shift. For example, if there are male patients on the ward who pose a risk to female staff, or female patients who can only be cared for by female staff, and the staff gender mix for a shift does not fit these working conditions, organising zonal observations becomes challenging.

ELFT has already carried out significant work on improving therapeutic and physical health observations. The report author makes four final reflections based on the analysis:

- The design of the therapeutic observation task shapes human behaviour to locate each patient – the task design is to carry out a ‘whereabouts observation’, rather than engage in therapeutic care. Task redesign is needed to effect cultural and behavioural change: Reminding staff to follow the observations policy and providing education (including on the importance of honesty in documentation) will not improve observations practice. The observations task design, carried out in the context of a ‘messy work system’ where staff adapt and troubleshoot emerging problems needs to be addressed.
- As expected, the human factors analysis has identified disconnects between ‘work as prescribed,’ ‘work as imagined,’ and ‘work as done.’ Going forward, there is a need to focus improvement work on reconciling these disconnects: This means reducing the

'turbulence' in the work system created by the multitude of factors identified in the report.

- The QI interventions of board rounding and zonal observations address some, not all, of the factors which lead to observations being missed, and falsification of observations. The report author acknowledges the interventions were never designed to address the multitude of factors identified in this report.
- The findings of the report, particularly those from the SEIPS Work System Explorer workshops, highlight the limitations of the current approaches to monitoring observation practice. Audits of compliance, including those which involve ward managers carrying out spot checks of observation sheets which are then plotted on an SPSS chart to give a % compliance measure of missed observations do not reflect 'work as done.' They measure, 'observation documentation.' Such measures do not give insights into how observations are performed, and the trade-offs, and adaptations staff make when carrying out observations.

Next steps

As a Human Factors Professional, the report author does not make recommendations without including end-users in their design and content. The next steps are therefore:

- For senior leaders at ELFT to consider the findings and implications of the report alongside other work being undertaken to improve observations practice.
- To develop a shared plan of the way forward, with a focus on where we can improve the work system, redesign tasks, and reconcile the gap between 'work as imagined,' 'work as prescribed,' and 'work as done' highlighted in the report.

1.0 Background

The report presents the findings of a thematic human factors analysis of therapeutic and physical health observations on adult in-patient acute and PICUs at ELFT. Dr Jane Carthey was commissioned to carry out a human factors analysis of a sample of serious incident investigation reports, and to gather insights into 'work as done.' 'Work as done' in the context of observations practice in mental health means how staff conduct both therapeutic and physical health observations on wards and in PICUs, and how they adapt and intervene in response to fluctuations, turbulence, and dynamic changes in the work system.

The thematic human factors analysis of observations practice at ELFT was commissioned following several patient safety incidents where mental and physical health observations were omitted, which in some cases, involved what is termed, 'falsification of observations,' (i.e. staff signing the observations sheet when observations had not been carried out). ELFT received a Regulation 28 Notice to Prevent Future Death, issued by the coroner, following an inquest into the death of a patient in August 2020. 'Falsification of observations' was raised in the inquest, although it did not contribute to the patient's death. Since the Regulation 28 Notice was issued, ELFT has identified further cases.

Since receiving the Regulation 28 notice, ELFT has carried out significant work aimed at improving observations practice, including the implementation of quality improvement interventions (i.e. board rounding, zonal observations and twilight shifts), educational packages, (including an Honesty in Documentation training module), and introduction of the Standardised Measurement of Observations (SOM) Tool. A digital application to provide improved observation documentation (using Microsoft PowerApps) has been designed and is currently being tested. Maintaining standards and quality in observations practice remains a challenge at both a national and local level.

The report's findings are based on:

- A deductive, human-factors based thematic analysis of twenty-six serious incident investigation reports. The Systems Engineering Initiative for Patient Safety (SEIPS) model (Holden, Carayon, et al., 2013, 2021) under-pinned the thematic analysis. SEIPS is a complex systems framework which enables exploration of the interaction between elements of the work system influence outcomes for patients, staff, and the broader organisation. SEIPS is the main complex systems framework used in the Patient Safety Incident Response Framework (PSIRF) toolkit (NHS England, 2022). PSIRF was implemented in organisations providing NHS-funded care from August 2022. PSIRF has replaced the former Serious Incident Framework (NHS England, 2015).

- Insights into 'work as done' elicited from six workshops and two one-to-one interviews with ELFT staff using the SEIPS Work System Explorer (NHS England 2022) to explore 'work as done' and 'pain points' (i.e. barriers and challenges in everyday work) which impact on how observations are carried out.

The approach to carrying out the analysis is presented, followed by a summary of the findings, highlighting what has been discovered about the work system around observations.

2.0 Scope

The scope of the current analysis is to carry out an analysis of the work system around therapeutic and physical health observations, using both past serious incident investigation reports and insights into work as done gleaned from workshops with staff working on adult acute in-patient wards and PICUs at ELFT.

The trust has carried out previous thematic analyses of serious incident investigation reports relating to incidents where the investigation identified 'falsification of observations.' The previous analyses have been reported through ELFT's governance structures. In September 2024, the report, Falsification of Observations Review was discussed at the 2nd September 2024, Quality and Assurance Committee. The Falsification of Observations report included twelve cases of Patient Safety Incident Investigations/Serious Incidents involving inpatient deaths from August 2018 to August 2024 where falsified or potentially falsified observations had been identified. The report also included a summary of on-going improvement work undertaken to improve therapeutic engagement practice in the Trust from 2021 to date.

The Director of Patient Safety & Patient Safety Specialist at ELFT has shared that although previous thematic analyses have been completed, it has proven difficult to identify common themes across the investigation reports. The current analyses focuses on adding to what has already been learnt about practice for therapeutic and physical health observations by applying a human factors lens to gain insights into the work system.

The human factors-based deductive thematic analysis is not restricted to cases where there was evidence of 'falsification of observations.' Its scope is to take a broader look at the 'work system' around observations practice at ELFT. The report aims to add to and complement current knowledge, and not to replicate previous work that has been completed internally.

3.0 Approach

The human factors-based deductive thematic analysis of serious incident investigation reports was informed by NHS England's PSIRF guidance document, *'Thinking thematically: top tips for completing a thematic review,'* (NHS England, 2022).

3.1 Developing inclusion and exclusion criteria for the analysis

Together with the Director of Patient Safety & Patient Safety Specialist (DD) and Serious Incident Reviewer (CP), a set of provisional inclusion and exclusion criteria were developed to scope out which serious incident investigation reports to include in the sample.

NB: The report author acknowledges the term 'serious incident investigation' is no longer used following the transition to NHS England's (NHSE) Patient Safety Incident Response Framework (PSIRF). For the current report, we use the term serious incident investigation report because the reports analysed were drawn from a sample of investigations carried out under the Serious Incident Framework (NHS England, 2015).

The inclusion and exclusion criteria are shown in Table 1:

Table 1: Inclusion and exclusion criteria used in sampling for the thematic analysis

Inclusion criteria	Exclusion criteria
Serious Incident Investigation reports that pertain to deaths of in-patients carried out from 1st January 2020 to 31st December 2023 , where Care Delivery Problems (CDPs) or Service Delivery Problems (SDPs) were identified on the theme of falsification of observations, or where significant workarounds from the therapeutic or vital signs observation protocols were identified in the investigation analysis. Note that the time for inclusion covers historic cases, where the incident occurred prior to 1st January 2020 but where the incident was reported and/or serious incident investigation started within the 1st January 2020 to 31st December 2023 time frame. 'By significant workarounds we mean the serious incident investigation report found evidence that it had become normal practice on the ward for either physical or therapeutic observations to be documented incorrectly, or falsified, and/or it was normal practice for physical or therapeutic observations to not be carried out at the prescribed frequency.'	Serious Incident Investigation reports where the investigation analysis identified one or two missed physical health or therapeutic observations but where the investigation team concluded there was no evidence of falsification of observations or significant workarounds that contributed to the incident.
The outcome was death caused by a deterioration in an in-patient's physical health or an in-patient suicide or homicide.	Serious incident investigation reports where the outcome was moderate or severe harm to the patient.

In June 2024, the Director of Patient Safety & Patient Safety Specialist, and Serious Incident Reviewer identified ten serious incident investigation reports which met the inclusion criteria set out in Table 1. They also identified a further twelve serious incident investigation reports which potentially met the inclusion criteria. The Human Factors and Patient Safety Consultant carried out an initial review of all twenty-two reports. One report was excluded from the sample because the patient died at home. Thus, the initial sample comprised twenty-one serious incident investigation reports.

In July 2024, an additional serious incident investigation report was identified (Datix 132260). A Prevention of Future Deaths notice had been issued by the coroner following the inquest into this patient’s death, and the PFD highlighted that there may be other historic incidents which met the inclusion criteria. Further exploration was carried out by the Director of Patient Safety & Patient Safety Specialist and the Serious Incident Reviewer in collaboration with the ELFT Legal Services team. Four more serious incident investigation reports were identified which met the inclusion criteria: (Datix 209864; Datix 186699; Datix 107366 and Datix 134929).

In total, twenty-six serious incident investigation reports were included in the sample for the human factors-based deductive thematic analysis. Appendix A provides a list of the reports included in the sample, together with DATIX numbers, ward type and name.

3.2 The approach to the human factors-based deductive thematic analysis

The sample of twenty-six serious incident investigation reports were analysed as follows:

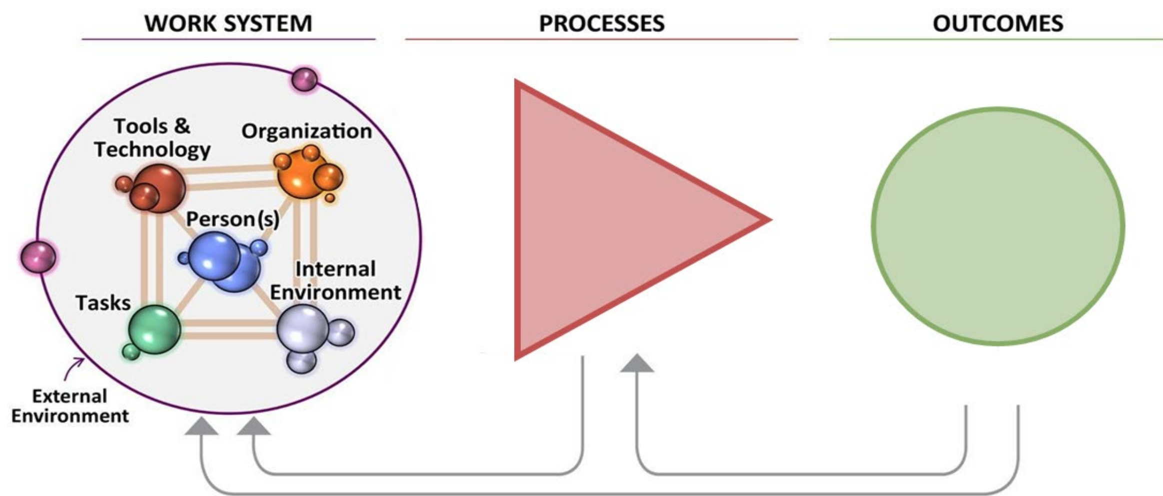
3.2.1 Analysis of contributory factors

The Human Factors and Patient Safety Consultant read each serious incident investigation report. The contributory factors identified in the twenty-six reports were classified using the elements of the work system in the SEIPS model (Holden, Carayan et al., 2013; Holden and Carayan, 2021) (see Figure 1). The elements of the work system in the SEIPS model are technology & tools, organisation, task, internal environment, person, and external environment. Patient safety incidents result from multiple interactions within the work system which in turn determine work processes and importantly, 'work as done.' Recognising that healthcare is a complex, dynamic system, SEIPS prompts us to look for interactions between elements of the work system rather than simple linear cause and effect relationships. By examining the different work system components and their interactions, recommendations and safety actions can focus on wider system issues, not individuals (NHS England, 2022).

SEIPS also enables us to consider a broad range of outcomes; for the patient, their loved ones, staff involved in a patient safety incident and for the organisation. In the context of observations practice, a broader range of outcomes to consider may be, for example:

- Patient: Deaths from unrecognised deterioration, physical health events or self-harm.
- Patients being treated on the ward where an in-patient died: Trauma of witnessing CPR, trauma caused by the incident occurring whilst being treated on the ward, PTSD etc..
- Staff directly involved in the patient safety incident: Trauma of being involved in a patient safety incident, PTSD, psychological harm, moral injury, loss of confidence, feeling of being under scrutiny, feelings of failure, defensiveness etc..
- Staff working on the ward where the patient died: Trauma, psychological harm, loss of confidence, feeling of being under scrutiny, feelings of failure, defensiveness etc..
- Organisation: Impacts other staff in the organisation. Leaders' concerns about observation practice on wards, feeling the patient and family have been let down by the organisation, sense of pressure to improve practice and 'solve the problem,' impact on safety performance, external scrutiny from regulators, the Coroner etc..

Figure 1: The Systems Engineering Initiative for Patient Safety: SEIPS model (Holden, Carayan et al., 2013; Holden and Carayan, 2021)



To ensure there was consistency and standardisation when classifying the contributory factors, the report author used NHS England's SEIPS on a Page (NHS England, 2022) and the SEIPS Work System Explorer (NHS England, 2022) (see Figures 2 and 3, respectively) when classifying contributory factors. SEIPS on a Page was developed by NHS England to provide an overview of the SEIPS Work System. The SEIPS Work System Explorer, developed by the report author, was developed to provide staff leading learning responses with a set of open questions to guide conversations about 'work as done.' Each contributory factor was analysed in turn, referencing both the, 'SEIPS on a Page' and SEIPS Work System Explorer.

Figure 2: SEIPS on a Page (NHS England, 2022)

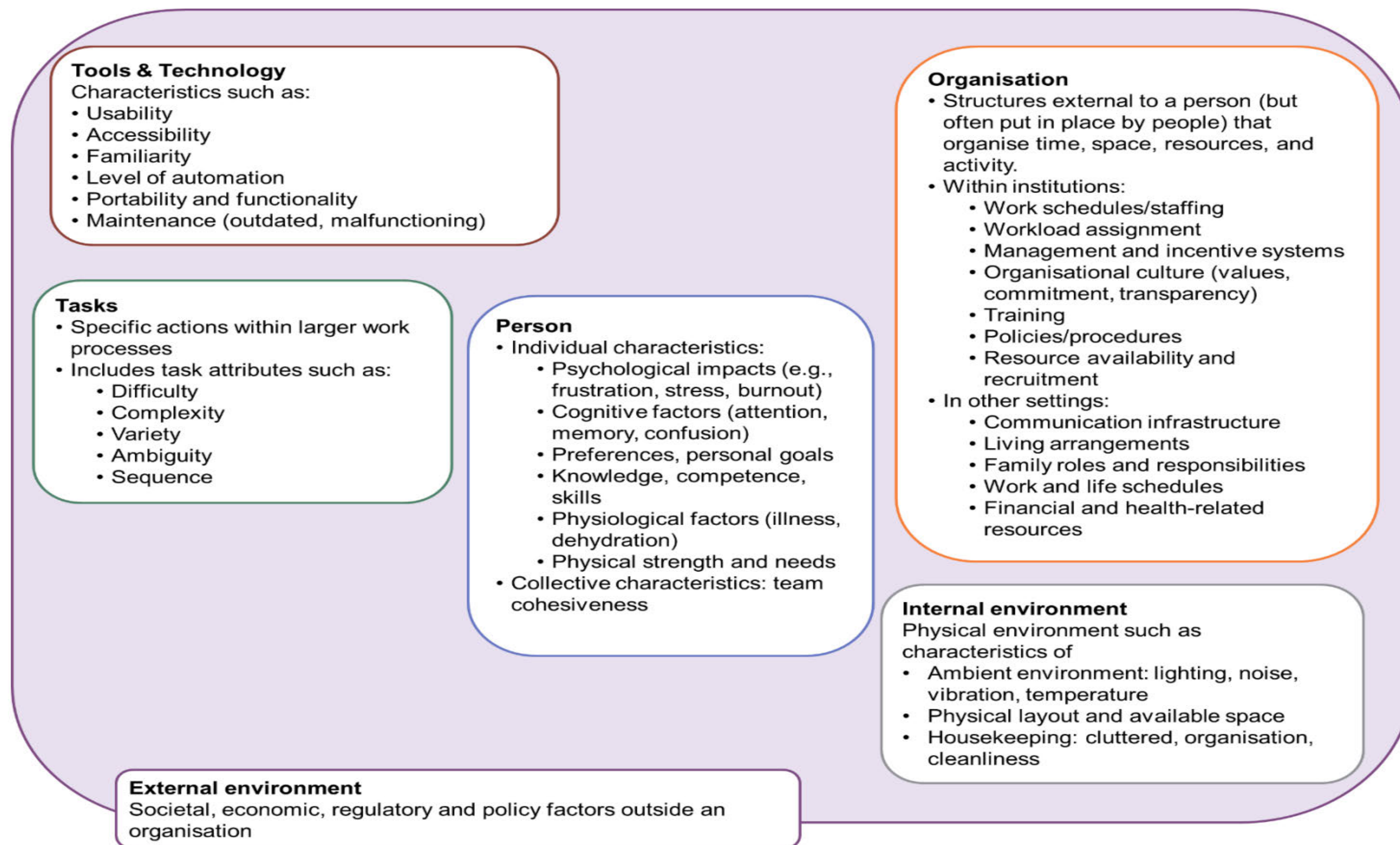
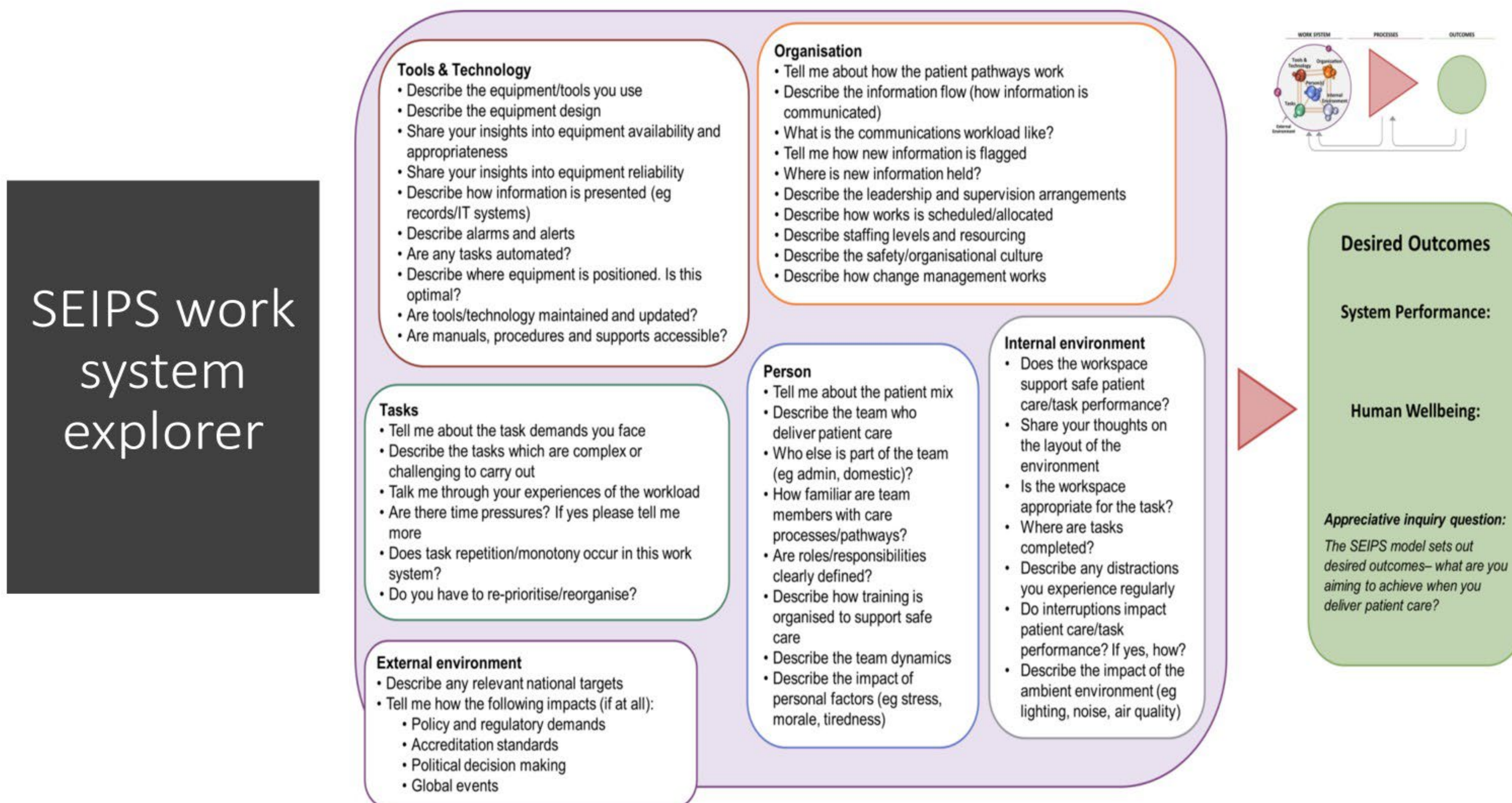


Figure 3: The SEIPS Work System Explorer (NHS England, 2022)



As expected with complex systems analysis, the contributory factors descriptions in the serious incident investigation reports did not neatly fit into one element of the SEIPS work system. For example, most contributory factors cannot be categorised solely as 'task' 'organisation, 'internal environment,' 'person,' or 'external influences.' The contributory factors described in the reports typically involved interactions (i.e. links) between two or more elements of the work system. Box 1 presents examples of what is meant by, 'interactions across elements of the SEIPS work system,' and how the contributory factors described in the reports were classified by the report author:

Box 1: Showing how contributory factors were classified as interactions across elements of the SEIPS work system

Example 1: Datix 176426
Contributory factor: '*..the Rio medical record documentation does not support the rationale/decision making for commencing food and fluid input monitoring. It remains unclear whether this was care planned,'*

The contributory factor was classified in the analysis as: The team/individual (i.e. person) responsible for carrying out food and fluid monitoring (i.e. the task) did not document the rationale for commencing food and fluid monitoring on Rio (i.e., technology & tools). Hence in the analysis, this contributory factor is classified as an interaction between the technology & tools, person, and task elements of the SEIPS work system.

Example 2: *Datix 116848*
Contributory factor: '*Although the nursing establishment was appropriate for the night shift the most senior nurse on duty (Staff Nurse C) was a bank staff member who had not worked on Ward X before. She had not received any ILS training whilst on bank in ELFT.'*

This was classified as an interaction between the 'organisation' (i.e. the nursing establishment for the night shift and the absence of provision of ILS training), the person (i.e. the senior nurse on duty being a member of bank staff), and the task, (i.e. the task of applying Intermediate Life Saving Skills during a medical emergency).

Example 3: Datix 91221:
Contributory factor: *Non-compliance to the Rapid Tranquilisation Policy: There were no observations completed and staff on ward Y could not have been aware if he had refused at the times specified or was asleep at the time noted as no member of staff actually checked.*
(i.e. the Rapid Tranquilisation Policy is part of the 'organisation' element of the SEIPS work system. The observations are a 'task' and the staff members who were responsible for carrying out the checks are part of the 'person' element of the SEIPS work system. Hence, this contributory factor was classified as an interaction between organisation, task, and person.

Example 4: Datix 207916.
Contributory factor: *'Prior to the inclusion of NEWS 2 on Rio, a paper version was used. Staff had to work out the score for each parameter themselves, as well as the total score. This meant that they were much more engaged with the process. On Rio, staff simply must enter each result and Rio calculates each score. This may mean that staff are more task-focused on completing each section of the form, but do not take an overall view of the outcome.'*

This was classified as and interaction between the technology and tools (i.e. NEWS 2 scoring system and Rio), person, i.e. the staff carrying out the NEWS 2 scoring and task (i.e. the task of calculating the NEWS 2 scoring).

Example 5: Datix 172230:
Contributory factor: The decision was for Mr A to remain on intermittent observations. It was acknowledged that the instruction regarding the level of observations and the rationale for that decision, was not included in the Ward round entry on Rio, although it is standard practice for this to be included.

This was classified as an interaction between the organisation (i.e. workload allocation of the level of observations and how this information from the ward round was flagged), the task (i.e. intermittent observations), the technology & tools (i.e. Rio) and the person (i.e. the staff member responsible for documenting the level of observations decision on Rio)

By classifying each contributory factor described in each investigation report using the SEIPS model, the report author iteratively developed a framework showing the types of interactions in the SEIPS work system (see Table 2).

Table 2: Elements of the SEIPS work system and work system interaction categories iteratively identified in the analysis of contributory factors

Framework of SEIPS work system elements and interactions
Technology & Tools
Technology & tools/Organisation
Technology & tools/Task
Technology & Tools/Organisation/Task
Technology & Tools/person
Technology & Tools/Person/External environment
Technology & Tools/Internal environment
Technology & Tools/External environment
Technology & Tools/External environment/Organisation
Technology & Tools/Task/External environment
Technology & Tools/Person/Task/Internal environment
Technology & Tools/Task/Person
Technology & tools/Person/Task/External environment
Organisation
Organisation/External environment
Organisation/Task
Organisation/Task/Person
Organisation/Task/Person/Technology & tools
Organisation/Task/Person/Internal environment
Organisation/Person
Organisation/Person/Internal environment
Organisation/Person/Technology & Tools
Organisation/Person/External environment
Organisation/Task/Person/External environment
Organisation/Task/External environment/Person/Technology and Tools
Organisation/Task/Internal environment/Person/Technology and Tools
Organisation/Task/Internal environment/Person/External environment
Person/Task/External environment
Person
Task/Internal environment/Person
Person/External environment
External environment
Task/External environment
Task/Internal environment
Task/Person
Internal environment/person

3.2.2 Mapping themes using the elements of the SEIPS work system

In the next stage of the analysis, 'SEIPS maps,' were developed. The SEIPS maps summarise the themes identified in the analysis (see Figure 5). Each SEIPS map describes the themes identified, denotes the Datix number of the serious incident investigation report(s) and where there are links to other elements of the work system.

This type of human-factors-based deductive thematic analysis highlights the frequency with which interactions between elements of the SEIPS work system are contributory to patient

safety incidents. Gathering insight into how frequently different types of interactions occur across elements of the SEIPS work system provides a diagnosis of the broader work system in which observations are carried out. The data can then be used alongside other sources of information to inform the design of solutions.

3.3 Analysis of recommendations

The recommendations in each of the investigation reports were classified using a human factors framework which differentiates between 'strong,' 'moderate,' and 'weak' recommendations.

- Weak recommendations are those which focus on fixing people, by telling them to comply with safety policies or procedures, do more training to raise their awareness of a safety process or do additional safety checks, or which involve rewriting policies and procedures, disseminating investigation findings or carrying out a review.
- Moderate recommendations focus on, for example, resolving workload or staffing problems, enhancing written or verbal communication, solving equipment availability problems etc..
- Strong recommendations involve, for example, redesigning healthcare processes, pathways, culture, and equipment – that is to say, their focus is on redesigning the healthcare system.

Where the recommendations in the incident investigation reports are weak, or where there are no strong recommendations, it increases the likelihood that the solutions put forward are unlikely to be effective or sustainable (Hibbert, Thomas et al., 2018). Where an investigation report has no strong recommendations, the same type of incident is likely to recur in the future.

Table 3 summarises the human factors framework of strong, moderate, and weak recommendations that was applied in the current analysis of recommendations. The framework is based on the research of Cafazzo and St Cyr (2012) and Hibbert, Thomas et al., (2018).

Table 3: Strong, moderate, and weak recommendations

Recommendation strength	**Types**
Strong	Redesign a healthcare pathway or process or other part of the work environment
	Engineering controls like designing in a 'forcing function.'
	Effect cultural improvement to develop a psychologically safe culture
	Redesign equipment, IT systems to improve their usability, accessibility, and functionality
	Simplify or standardise processes, pathways, or equipment
	Carry out usability testing (formative and summative) when implementing new equipment, workplaces or IT systems.
Moderate	Resolve equipment availability problems
	Resolve staffing problems
	Reorganise workload to address high workload or task overload
	Develop and deliver simulation-based training
	Enhance documentation or communication
	Eliminate or reduce distractions and interruptions
	Introduce a safety checklist
	Review roistering or the appropriateness of the staff mix.
Weak	Add in additional safety checks for staff to carry out
	Raise staff awareness of a policy or process
	Carry out an audit or review
	Increase staff supervision
	Informing, notifying, issuing warnings
	Discipline or suspend staff who make errors
	Re-write safety policies and procedures
	Introduce more safety policies and procedures
	Check staff understanding of safety processes (without considering work as done).
	Share the investigation findings
	Carry out didactic training which involves reminding staff about safety policies and procedures, or 'counselling' staff about the way to deliver safe patient care.
	Other recommendations which do not take account of the work flow and task demands in a clinical area.

3.4 Insights into 'work as done' using the SEIPS Work System Explorer

Six workshops (five face-to-face and one virtual on MS Teams) were carried out with ward and PICU teams to further explore 'work as done' relating to observation practice. In addition to the six workshops, two one-to-one interviews were carried out (one with a social therapist and one with a RMN). Workshop participants included, ward managers, RMNs, social therapists, bank nurses, psychologists, nurses in charge etc..

The workshops used the SEIPS Work System Explorer to explore the work system around therapeutic and physical health observations. The workshops focused on understanding everyday challenges which make it difficult for staff to complete observations at the prescribed frequency, how documentation tasks around observations are designed, and how

observations fit into the overall work flow on an adult inpatient acute ward or PICU. Appendix B describes the process for facilitating a SEIPS Work System Explorer workshops.

The SEIPS Work System Explorer was designed to gain insights from frontline healthcare professionals about 'work as done.' Whilst learning from incidents, complaints, and audits, is important, there are limits to how much safety improvement can be achieved by learning through the 'rear view mirror' at past events. Additionally, audits which focus on measuring 'compliance' with a healthcare process, for example, completion of observation documentation also have limitations: Compliance audits can foster workarounds and a culture of 'what is measured gets done,' where, for example, staff document the observations as being completed because they the metric of achieving a 99% compliance rate becomes the primary goal, over-riding carrying out a good quality observation. Compliance audits also do not reflect the complexity of delivering care in the real world: Rather, listening, perceiving, and observing how care is delivered, and how staff and patients experience the delivery of care is vital to get deeper insights into 'work as done.'

4.0 Findings

4.1 Demographic breakdown of reports

Twenty-six serious incident investigation reports were included in the sample. The reports related to incidents occurring on nineteen wards at ELFT. Table 4 shows the breakdown per type of ward.

Table 4: Frequency of serious incident investigation reports per type of ward

Type of ward	Number of incident investigation reports
Adult in-patient acute – male	12
Adult in-patient acute-female	9
Older adult in-patient wards	2
Low or medium secure in-patient rehabilitation unit (forensics)	2
PICU	1

4.2 Contributory factors analysis

4.2.1 Frequency of contributory factors

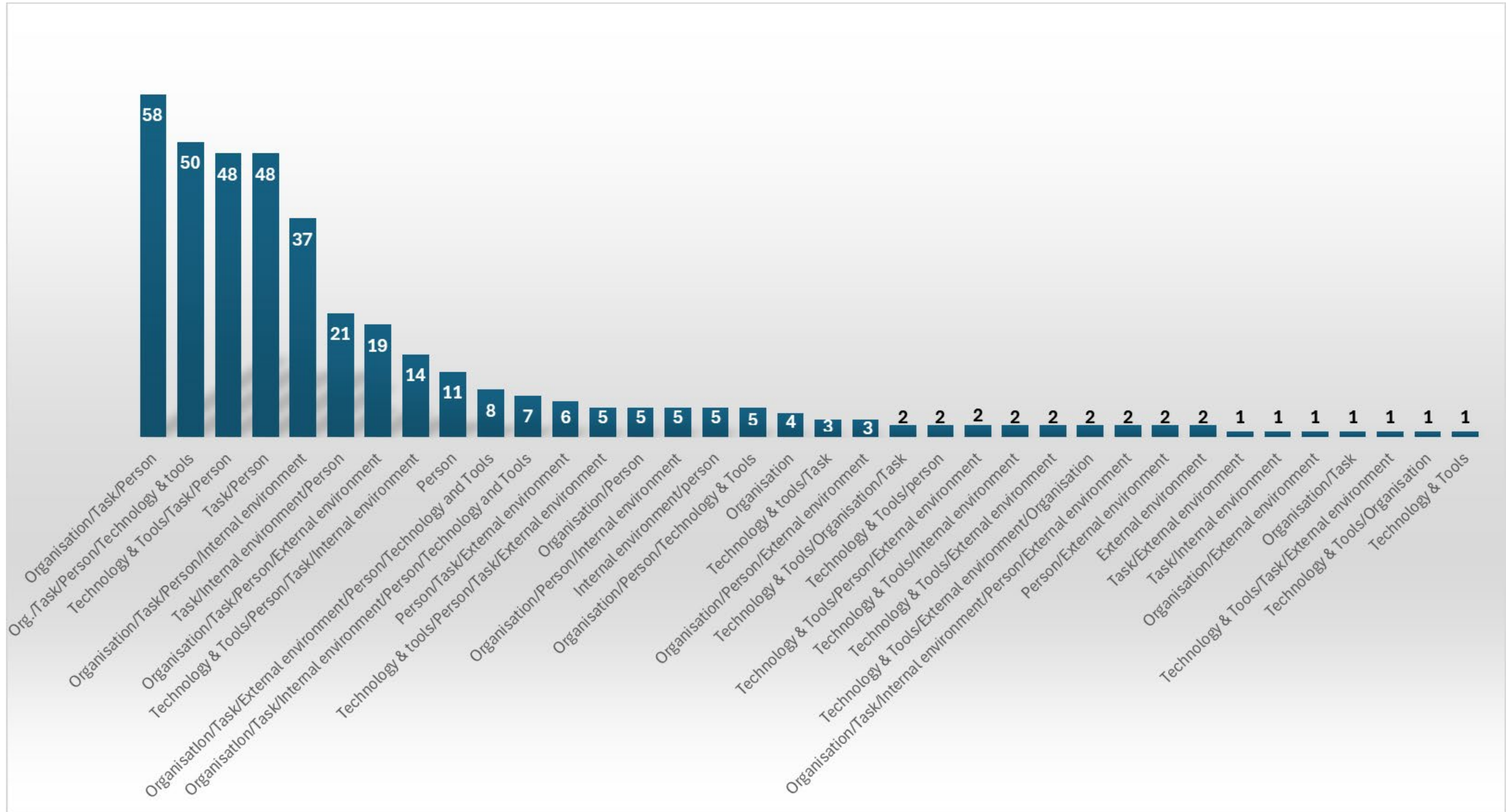
Figure 4 shows the frequency with which contributory factors were classified per element or interactions between elements of the SEIPS work system. Figure 4 shows that the most frequently occurring interaction identified was between 'organisation/task/person' elements of the SEIPS work system: Fifty-eight contributory factors were classified as interactions between the 'organisation/ task/person' elements of the work system. The second most frequently occurring interaction was, 'organisation/task/person/technology & tools': Fifty contributory factors were classified as this type of interaction. The joint third most frequently occurring interactions were 'technology &tools/task/person' or 'task/person': Forty-eight contributory factors were classified either as interactions between 'technology &

tools/task/person’ or ‘task/person’ elements of the SEIPS work system. Thirty-seven contributory factors were classified as interactions between the ‘organisation/task/person /internal environment’ elements of the SEIPS work system. Twenty-one contributory factors were classified as interactions between the ‘task/internal environment/person’ elements and nineteen were classified as interactions between ‘organisation/task/person/external environment.’ Fourteen were classified as interactions between the ‘technology & tools/person/task/internal environment’ elements of the SEIPS work system.

Figure 4 also shows that eleven contributory factors were classified into the ‘person’ element of the SEIPS work system, eight into ‘organisation/task/external environment/ person/technology & tools,’ and seven were interactions between ‘organisation/task/internal environment/ person/technology & tools.’

Two-hundred and ninety-five out of three hundred and eighty-six contributory factors, i.e. seventy-six percent of the total number of contributory factors were classified into the top eight categories in the SEIPS analysis (see Figure 4).The remaining contributory factors were classified into categories that had a frequency of six or less.

Figure 4: Classification of contributory factors per elements of the SEIPS work system



4.2.2 SEIPS – mapping of themes

Figure 5 summarises the themes identified from the human-factors based deductive thematic analysis of contributory factors. The SEIPS maps give an over-riding picture of the complexity of factors that contribute to patient safety incidents involving observation practice. As stated earlier in the report, previous thematic analyses carried out internally at ELFT has found it challenging to identify common themes across investigation reports. What the SEIPS mapping shows is that there are diverse range of interconnected factors at play, relating to technology & tools, task, organisation, person, internal environment, and external environment. Some headline findings from the SEIPS thematic analysis are:

- Across the organisation, technology & tools, task and person elements of the work system, there are numerous examples of disconnects between 'work as prescribed' and 'work as done.' There are numerous examples of contributory factors where care as it is envisaged or prescribed in policies, procedures and guidelines does not match how observations are carried out on wards and in PICUs. For example, there were disconnects between what is prescribed in policies and procedures relating to observation, rapid tranquilisation, physical health, searches, VTE risk assessment, falls risk assessment, care planning, risk assessment and incident response, and 'work as done.'
- The SEIPS maps illustrate that the task of carrying out observations, (both therapeutic and physical health), is inter-connected with and influenced by other processes including organisation of staffing, admissions, handovers, MDT meetings, ward rounds, and escorted leave. It is also impacted by dynamic changes on a ward or PICU, for example, staff responding to another incident, a patient being stepped up to 2:1 observations midway through the shift and distractions and interruptions.
- The SEIPS maps highlight a theme around allocation of observations and reallocation of observations in response to dynamic changes during a shift. This is a theme across all six elements of the work system (technology & tools, task, person, internal environment, external environment, and organisation). The theme of 'allocation' is closely linked to 'work scheduling' in the organisation of the SEIPS map.
- The SEIPS maps also highlight a general theme around the design of the task of therapeutic observations: Observation sheets (i.e. the technology & tools) comprise codes denoting a patient's whereabouts, and the task name 'observation' shapes staff behaviour to locate each patient or monitor them, rather than engage in therapeutic care.
- The SEIPS maps also highlight gaps in emergency response, and/or the impact of a previous incident on carrying out observations: This is a theme across all five of the six elements of the work system (technology & tools, task, person, internal environment and organisation).
- The 'organisation' element of the SEIPS work system was the element where there were the most contributory factors (albeit often interactions with other elements of the work system). The organisation part of the SEIPS map highlights gaps in information

flow across MDTs, in policies and procedures, staffing, skill mix, training and induction, work scheduling, how new information is flagged and safety culture.

- The ‘technology & tools’ part of the SEIPS maps highlight contributory factors relating to the functionality, accessibility, and design of IT systems (e.g. Rio), and paper-based systems like, observations sheets, whose design shapes the behaviour of staff carrying out the task of observations into recording a patient’s whereabouts, rather than supporting a therapeutic conversation. Also notable is the design of food and fluid charts, BM charts, and the NEWS 2 scoring system when used on in-patient mental health wards and PICUs. There are also several contributory factors linked to equipment use when responding to an emergency.
- The ‘task’ element of the SEIPS map also describes a diverse range of task-related factors including task demands, task sequencing, carrying out the routine (at times monotonous) task of observations, task prioritisation, challenging tasks, task ambiguity, familiarity and clarity of roles and responsibilities.
- Like the ‘task’ element of the work system, the ‘person’ element comprises a diverse range of factors including knowledge/competences/skills of staff, psychological and cognitive impacts of being involved in a patient safety incident, team culture, individual characteristics, physical well-being, and individual preferences.
- High acuity on the ward was the most frequently identified theme in the ‘internal environment’ part of the SEIPS map.
- The ‘external environment' element of the SEIPS map highlights the impact of the COVID-19 pandemic. It is the element of the work system which had the fewest contributory factors mapped onto it.

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis- Technology & tools

Technology & Tools

- **IT functionality and reliability** including connectivity, IT outages, design of NEWS 2 template on Rio (155136, 162980;124655) *(links to organisation and task).*
- **IT accessibility:** No handheld devices or mobile computers to record observations as they are carried out (207916) *(links to person, task, organisation)'*
- **IT accessibility:** Different electronic record system used by the AMHP service (176426) *(links to external environment)* or acute hospital (e.g. HEI system for RLH hospital (157482), *(links to person, task, external environment)*
- **Duplicate IT and paper documentation** : Examples include Rio and the paper NEWS chart (113911; 116848; 207916), BM chart (159260), the on-call manager log and Rio electronic patient record (176426) *(links to task and person)*
- **Presentation of information on IT systems:** Design of Rio electronic system for calculating NEWs 2 scores: Rio function which automatically calculates the NEWS 2 score potentially impacts staff interpretation of the significance of the score (207916) *(links to task and person).*
- **Presentation of information on IT systems:** Doctor documented stepping up the of level of observations on Rio without communicating this directly to the nurses. (141835; 207916) *(links to task, organisation and person).*
- **Lack of standardisation in the design of an IT system***:* On Rio, risk of self-harm can be documented in progress notes, on risk assessment forms and in safety plans (141835; 207916)*(links to person, task, organisation)*
- **No system to document** who is responsible for carrying out observations (207916)*(links to person, task, organisation)*
- **The design of the observations sheet:** Observation sheet comprises many codes to denote a patient's whereabouts: The observation task has been designed to focus on a patient's whereabouts (186699) *(links to task, and person)*
- **Power supply outage,** e.g. affecting medication dispensing (167593), *(links to task and person)*
- **Batteries not charged,** e.g. laptops (167593) *(links to person, organisation and task)*
- **Access to equipment used to self-harm,** e.g. needles, (159260) *(links to external environment, person)*
- **Tool design:** Design and use of NEWS 2 chart in context of patients taking psychotropic medications which increase heart rate, or who have diagnoses of high blood pressure and diabetes (2071916)*(links to person, task, external environment)*
- **Tool design:** The Food & Fluid template is based on the inpatient acute model (170863 *)(links to external environment and task)*
- **Alarms:** Staff response to an emergency: Emergency alarm or pinpoint alarm not activated (141835, 199283;107366) or alarms cancelled (204370), or delay in calling 999 (207916;199283;107366)(*links to task, person, and organisation)*
- **Equipment no longer in use:** Tabards to increase visibility of staff carrying out observations (171073) *(links to person and task)*
- **Equipment not used:** PPE not donned when responding to an emergency (141835; 132260); back up laptop not used (167593) *(links to task, person);* radio to communicate information across the team when responding to an emergency (107366) *(links to person, task and organisation)*
- **Equipment not used:** Food and fluid charts not used to monitor patient's dietary intake (159260)

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis- Technology & tools

Technology & Tools (continued)

- **Work as prescribed vs. work as done:** Mismatch between BM chart requirement which requires staff to document BM 4X per day (as per BM chart) and the patient who did not eat four meals a day (159260) *(links to task and person)*
- **Work as prescribed vs. work as done:** Food and fluid intake documented in Rio progress notes, not on fluid and food intake charts (170863) or not documented (176426)*(links to task and person)*
- **Work as imagined vs. work as done:** Staff on mobile phones or wearing headphones when carrying out observations (155136, 199283) *(links to task, person and organisaton)*
- **Work as prescribed vs. work as done:** NEWS 2 scoring: Not all parameters assessed (141835), inconsistent use of or inconsistent NEWS scoring (124655)*(links to task, organisation and person),*
- **Familiarity:** AMHP service had recently updated their referral form (176426) *(links to external environment, task and person)*
- **Equipment positioning:** White board in nurses office used to display observation timetable and observation sheets (171073;134929) *(links to task, person and organisation)*
- **Level of automation:** There is no electronic monitoring systems in place to check for heat/movement of patients whilst in their room and this means ward staff rely on observing the chest raising or hearing a patient snoring. *(159260) (links to internal environment, task, person)*
- **Equipment availability:** No torches available to use when the lights were switched off (199283) *(links to task, person and internal environment)*
- **Accessibility:** CCTV footage is owned by an external contractor (176426) *(links to organisation and external environment)*
- **Reliability of information on IT system:** Patient's NOK address incorrectly recorded on Rio (176426) *(links to task, person, external environment)*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis- Person

Person

- **Work as prescribed vs. work as done.** Patient who was on ward leave did not attend (DNA) and appointment and this was not escalated (219002) *(links to task, technology & tools, and organisation);*
- **Psychological impact:** Trauma of responding to a traumatic, unexpected event leads to error completing the observations sheet (i.e. observations documented as carried out when they were not) (134929)/ Panic and stress of staff member in an emergency meant they did not use alarm (141835; 199283) or respond quickly to an emergency (171073; 116848; 107366, 219015) *(links to organisation, technology & tools and task)*
- **Knowledge/ Competence/Skills:** Staff understanding of the requirements in the Observations Policy re. signing on behalf of other team members being fraud (i.e. competencies) (186699) and Compilation of a list of updated signatures for all substantive and bank staff - NAME, Full Signature, Initials signature to ascertain clearly who does the observations (186699) *(links to organisation and task)*
- **Knowledge/Competence/Skills:** Staff understanding of the effects of the drug Spice and Guidance for Managing the Intoxication on Inpatient wards policy (141835) *(links to organisation and task)* and non-clinically trained staff ability to interpret vital sign observations (207916) or interpret NEWS 2 scoring (HCAs) (141835) *(links to organisation, technology & tools and task)*
- **Cognitive factors:** Staff member forgot to carry out observations (118985, 171073); did not update Rio risk assessment after incident of self harm (167593) *(links to task and technology & tools)*: Staff member forgot to document the medication given to a patient (207916)
- **Cognitive factors**: Attention: Staff member misread a patient's appointment information and date (219002)*(links to technology & tools, organisation and task)*
- **Cognitive factors**: Tying ligatures was normal behaviour for the patient (167593)
- **Cognitive factors:** Staff member left ward to collect item from her car when on observations duty (171073)
- **Psychological and cognitive impacts** (confusion, stress, beliefs, shock): Delay starting CPR and Resuscitation Policy not followed during CPR (116848; 107366; 199283) *(links to task, organisation and technology & tools).*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis - Person

Person (continued)

- **Psychological impacts:** Agitated, distressed patients not consenting to tests, observations or treatment (118985)
- **Team culture:** Staff member encouraged to sign the observations sheet retrospectively by other ward staff on duty that night (118985) and Another staff member signs the observation sheet when their colleague is the person who has completed the observations (10736 6), *(links to task, organisation, technology & tools)*
- **Team culture** where signing observations sheets when the observation were not carried out was the norm (167593), *(links to task, organisation, technology & tools)*
- **Physical well -being:** Low red blood cell count of haemoglobin could have made patient feel dizzy (157482)
- **Physical well -being:** Patient's age was 67 and this impacted perceptions of his level of frailty (155136) *(link to internal environment and organisation)*
- **Human error:** Medication signed as given in error *(207916) (links to task, organisation and technology & tools)*
- **Individual patient characteristics:** NEWS score of 2 normal for the patient, so transfer to A&E was not organised. (118985) *(links to task, technology & tools):*
  Individual patient characteristics: *Patient's* family history of VTE not known so could not be recorded on ELFT's VTE algorithm *(176426) (links to organisation, task and technology & tools)*
- **Individual patient characteristics** : CIWA score not recalculated because the patient was agitated (132260); patient semi-conscious (132260); *(links to task and technology & tools)*
- **Personal preferences:** Patient who preferred to sleep on a mattress on the floor in their room (107366) *(links to technology & tools, internal environment and task)*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis- Task

Tasks

- **Order of task completion (work as imagined vs. work as done):** Observation sheet completed later in the shift, not immediately after the observation has been carried out (134929) *(links to person, technology & tools, and organisation)*
- **Work as prescribed vs. work as done***:* Staff not carrying out observations at the set time (107366; 91221;171073; 172230; 141835;167593; 157482;209827;159260;116848; 118985) *(links to person, organisation)*
- **Work as prescribed vs. work as done***:* Observation sheet (134929) or test results documentation completed later in the shift, not immediately after the observation has been carried out (207916; 172230; 209827) *(links to technology & tools, person, organisation).*
- **Work as prescribed vs. work as done***:* Observation sheet or information documented on Rio does not reflect the observations that had been carried out or telephone calls with family members (167593; 118985;132260) *(links to technology & tools, person, organisation)*
- **Work as prescribed vs. work as done:** Observations carried out but are not documented on Rio (162890)*(links to person, organisation and technology & tools).* Patient's CIWA score not recalculated and documented on Rio (132260) *(links to person and technology & tools).*
- **Work as prescribed vs. work as done:** Blood tests carried out and results available but not reviewed by the medical team (159260) *(links to organisation, person)*
- **Work as prescribed vs. work as done***:* Escalation process for NEWS not followed (116848; 162980;157482) *(links to task, technology & tools, person and organisation)*
- **Last task at the end of a sequence of tasks:** Staff typically conduct hourly observations in chronological room order, starting with Room 1. Patient was in Room 15 and was therefore seen at the end of the observation round (107366) *(links to internal environment, organisation and person)*
- **Task design:** The observation task has been designed to focus on a patient's whereabouts (186699; 141835) *(links to tools & technology & person)*
- **Task allocation:** Allocating both general observations and intermittent observations to a staff member who has not been trained in carrying out observations e.g. bank band 3 (118985) *(links to person and organisation)*
- **Competing task demands:** Staff member called away to assist with an emergency on another ward (167593) *(links to organisation category)* and Staff member allocated to do observations was caught up doing another task (118985)
- **Task demands/workload:** The requirement for 15-minute observations for recently admitted patients increases pressure on staff, especially on wards with pre-existing high levels of acuity. (132260 and 172230) *(links to organisation, person, external environment and internal environment)*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis -Task

Tasks

- **Task allocation/work as imagined**: Shift coordinator thought that the bank band 3 was trained in observations (118985). *(links to person and organisation).*
- **Task demands:** Nurse not present when On Call Doctor clerked the patient for admission (172230) *(link to person, task and organisation)*
- **Challenging task:** Carrying out observations overnight when a patient is asleep in their room (207916; 107366) *(links to technology & tools, internal environment and person),* including, looking through the observations panel, (132260; 219015; 159260), or shutter (116848), or portal (199283) .*(links to technology & tools, internal environment (i.e. ambient environment) and person)*
- **Challenging task:** Patient refusing to have vital sign observations taken (113911) *(links to task)*
- **Routine tasks:** Once daily physical health observations not prescribed (162980) *(links to person and organisation)*
- **Routine tasks**: Updating physical health and risk assessments – key information not included (209064)
- **Task familiarity:** Both qualified and unqualified nursing staff on the ward, and clinical staff were unfamiliar with treating a patient with sca bies in an inpatient ward setting (209864) (links to organisation, person, task and internal environment)
- **Task ambiguity:** Contradicting documentation for the reasons for placing patient on Continuous Eyesight Observation (155136)
- **Task sequencing/Task prioritisation:** The Ward Doctor documented in his admission summary that an ECG had not been done, but should be carried out as soon as the patient was amenable **(**118985) *(links to technology & tools, and person)*
- **Task prioritisation:** No documented plan to review observations after patient had tied a ligature (167593) *(links to organisation and person)*
- **Task clarity:** Care plan did not specify what staff should look out for (107366) *(links to person and technology & tools)*
- **Competing task demands:** Following an incident, the staff responding were managing the competing tasks of containing alleged perpetrator versus treating the injured patient (199283) *(links to person and internal environment)*
- **Workload reallocation/clarity of roles and responsibilities:** Reallocation of observations to another team member when the team member originally allocated the observations task becomes unavailable (118985)*(links to person and organisation)*
- **Clarity of roles and responsibilities:** Team members are not clear who is carrying out the observations (171073); medical team did not routinely review vital signs observations on Rio, and thought the nurses did this task (207916) *(links to organisation, technology & tools, and person)*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis -Internal environment

Internal environment

- **Last task at the end of a sequence of tasks:** Staff typically conduct hourly observations in chronological room order, starting with Room 1. Patient was in Room 15 and was therefore seen at the end of the observation round (107366) *(links to task, organisation and person)*
- **Ward acuity/responding to dynamic events:** It was acknowledged that the ward was extremely busy with a high acuity of a total of 18 unwell patients – one patient had been grabbing staff and was escalating in agitation and demanding to be let off the ward and a history of ass aulting staff members. Another patient had to be transferred to the RLH with two escorting nurses and they had to remain with this patient for the r emainder of their shift, so they did not return to the ward. After the patient was transferred to RLH this left four members of staff including one unqualifie d member of staff on the ward. (132260) *(links to organisation, person, task, and external environment).*
- **Ward acuity/responding to dynamic events:** The ward was 'chaotic' on return from assisting as part of the rapid response team, so the staff member was unable to observe the patient every 15 minutes (167593), *(links to organisation, person, task).*
- **High acuity on ward** – four COVID-19 patients (171073) and high acuity impacted on handover (155136; 132260; 204370) *(links to organisation, task, person and external environment)*
- **High acuity on ward:** High a cuity on the ward impacted staff's ability to access Rio records (172230) or maintain food and fluid charts *(*170863) communicate with patient's family (170863)(*(links to task, organisation, person, technology & tools);*
- **High acuity on ward:** Numerous patients awake overnight impacted on carrying out observations *(141835) (links to organisation, person, task)*
- **High acuity on ward:** High ward acuity was caused by lack of PICU capacity *(*170863) *(links to organisation, person)*
- **Distractions and interruptions during observation tasks:** which impact on observations (199283) *(links to task, organisation and person)* or responding to an emergency (209064) *(technology & tools, organisation task, person)*
- **Impact of another incident on the ward:** Distractions and interruptions during observation tasks , (159260) *(links to task, organisation and person),*
- **Impact of another incident on the ward:** Panic alarm activated at a time ward was busy and there had been several previous incidents (209864)
- **Impact of another incident on the ward environment:** Nursing office door kept closed following previous incident and staff were observing the patient at night through glass panel in the door *(199283) (links to task, organisation and person)*
- **Physical layout of ward:** There are CCTV blind spots on the ward *(176426) (links to technology & tools)*
- **Workspace to support safe task performance:** Patient was being nursed in isolation impacting on the care they received (132260; 209864)*(links to task, technology& tools, person).*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis- External environment

External environment

- **Medical appointments outside the mental health hospital:** Staff who were listed on the allocation sheet as being the staff who would carry out the observations had to leave the ward to escort a patient to hospital (132260) *(links to task, technology & tools, organisation and person)*
- **COVID 19 pandemic impact on internal ward environment, person (staff) and tasks:** At the time of the incident all patients admitted to wards were nursed in the isolation section of Ward X (acute adult ward) as per ELFT admissions process and commenced on 15 -minute observations. The need to continue 15-minute observations for recently admitted patients increases pressure on staff, especially on wards with pre-existing high levels of acuity (132260) (also 171073, 170863; 176426) *(links to task, internal environment, organisation and person)*
- **COVID-19 pandemic impact on staff awaydays and supervision, and inclusion of bank staff** due to staff sickness and staff shielding (141835) *(link to organisation and person)*
- **Documentation** by external provider was incorrect & not uploaded onto Rio (176426) *(links to task, person, technology & tools)*
- **High workload** for AMHP Service (155136) *(links to task, person, organisation, internal environment)*
- **Coroner's Court:** Prevention of Future Deaths notice issued to the trust (167593) *(links to task, person, organisation)*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis -Organisation

Organisation

- **Work as prescribed vs. work as done:** ELFT Observation Policy V6 which states that staff should not undertake more than one consecutive hour of observations at a time. *(links to person and task):* Trust Policy states that a minimum of one third of observations should be undertaken by a qualified member of staff i.e. an RMN. Ward staff have stated that this is not always practicable.(141835) *(links to task and person)*
- **Work as prescribed/work as imagined vs. work as done:** Capacity assessment, (consent to admission and consent to treatment), was not completed on the ward within 24 hours of admission (159260) *(links to person and task);* NEWS chart not completed, no BM level documented, and no documentation of patient's refusal to have vital signs taken (159260) *(links to technology & tools, person, task)*
- **Work as prescribed vs. work as done** Staff on the ward did not undertake patient's heart rate, blood pressure, respiratory rate, temperature and level of consciousness every 15 minutes in accordance with the ELFT V6 policy on Rapid Tranquilisation (132260) *(links to person, task, internal environment).*
- **Work as prescribed vs. work as done***:* Non-compliance to the Rapid Tranquilisation Policy: There were no observations completed and staff on ward Y could not have been aware if he had refused at the times specified or was asleep at the time noted as no member of staff actually checked *(links to person, task, internal environment)..*
- **Work as prescribed vs. work as done:** Physical health assessment not completed on admission to the ward (113911) *(links to person, task, internal environment)*
- **Work as prescribed vs. work as done:** Patient stepped down from 15-minute observations without the decision being discussed in the MDT or with the senior nurse in charge or medic, and without considering his physical health risks (159260) *(links to task and person)*
- **Work as prescribed vs. work as done:** ELFT Incident Policy v8 not followed in terms of support for bereaved relatives *(167593) (links to task and person)*
- **Work as prescribed vs. work as done:** Section 117 meeting not carried out prior to discharge (176426) *(links to person and task)*
- **Work as prescribed vs. work as done:** VTE risk assessment not carried out on admission to the ward in accordance with Physical Healthcare Policy (176426;113911) *(links to technology & tools, person, task and internal environment)*
- **Work as prescribed vs. work as done:** Falls risk assessment not carried out on admission in line with the ELFT Manual Handling Policy (2020) (157482) *(links to technology & tools, person internal environment and task)*
- **Work as prescribed vs. work as done:** The Safe Environment and Search Policy (ELFT August 2018) was not followed – patient not searched (91221) *(links to task, person, internal environment)*
- **Work as prescribed vs. work as done:** Care plan and risk assessment not updated on admission/transfer to ward (113911; 116848) *(links to task, person, internal environment)*
- **Organisational response to staff signing for observations carried out by others:** Email was sent to all staff reminding them of policy and protocol for signing observations and that signing on behalf of others is fraud (186699) *(links to person and task)*
- **Management systems (audits):** Arrangements to audit NEWS2 scores were not in place on the ward (207916) and arrangements to audit observations sheets were not in place on ward (170863) *(links to task, technology & tools, and person)*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis- Organisation

Organisation

- **Information flow:** Organisation of COVID-19 testing and test results (171073) *(links to task, technology & tools)*
- **Information flow:** No clear debriefing process to support staff following an incident (91221) *(links to task and person)*
- **Information flow:** Across the MDT re. level of observations (level of observations not recorded in ward round entry on Rio) (172230) (also 15748 2;134929) including communication about CIWA (172230); changes in allocation of responsibility for observations (132260), care planning (134929) *(links to person, technology & tools, and task)*.
- **Information flow:** Across the MDT re. information shared at team awaydays to bank staff (141835); psychologist's formulation not shared across team (134929)*(links to person, technology & tools, and task);* decision to admit (159260); information not shared about relative's phone calls to ward (167593).
- **Information flow:** Across the MDT to ambulance service about which ward to attend (167593); to Deputy Fire Officer to escort emergency services once they arrived on site (107366) *(links to organisation, task, internal environment and external environment)*
- **Information flow:** Across the MDT to ICT team about a patient isolating with scabies (209864); handover from psychiatric liaison service (157482) about medication administration (207916) *(links to task and person)*
- **Information flow:** Across the MDT**;** shift work, leave and pressing commitments, meant ICT Champions may not manage to regularly give webinar briefings (209604) (link to person, task, technology & tools)
- **Information flow**: To patient's family about their admission (170863), appointments (219002) or death (167593; 176426) *(link to task, technology & tools, and person)*
- **Information flow/culture:** Bank staff not included in the Team Away days (141835) *(links to person and task)*
- **Patient pathways/culture:** Patient transferred from ward A to ward B in the early hours (141835)*(links to task, internal environment and person)*
- **Patient pathways:** Patient transferred directly to ward because triage unit was busy (159260) *(links to task, person and internal environment)*
- **Patient pathways**: Patient transferred from acute hospital on a Sunday (157482) *(links to task, person, external environment)*
- **Management system to oversee competencies**: Local observation register (which records which staff are up-to-date with observation competencies) is held for substantive staff only and not temporary staff (bank and agency staff). (141835) *(links to task, person and technology & tools)*
- **Patient pathways/work schedules:** Organisation of ECT referral paperwork and service at acute hospital (167593) *(links to task, person and external environment)*
- **Policies and procedures:** No organisational policy on use of mobile phones when on duty caring for patients (155136) *(links to task, person and technology & tools)*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis - Organisation

Organisation

- **Organisation of work – emergency response:** The ward was noted as not being busy during the day and therefore no extra staff were booked for the night shift. There were two RMN staff and one Social Therapist working on the night shift. The Social Therapist was part of the RRT and had been called away to two emergencies which resulted in them being absent from the ward. This is the normal staff quota for a night shift at that time (167593) *(links to task, person and internal environment)*
- **Organisation of work – emergency response:** Incident occurred in the early hours when patients typically need staff help with personal hygiene requirements; this contributed to a delay in responding to the emergency (204370) *(links to person, task, internal environment)*
- **Organisation of work – emergency response:** Timing of the incident for patient being nursed in isolation coincided with breakfast, the medicine round, and patients being escorted for fresh air breaks (171073) *(links to person, task, internal environment)*
- **Policies and procedures:** At the time of the incident, ELFT's policies did not provide guidance as to how often vital observations monitoring should be carried out, or steps to escalate results that are out of range, (207916) *(links to person, technology & tools, and task)*
- **Policies and procedures:** The Physical health policy does not cover food and fluid intake and patients declining to eat and drink (176426) *(links to person and task)*
- **Policies and procedures:** No guide within the ELFT Clozapine policy V3 (2018) on Troponin levels and what timescales a referral to the Cardiology service should take place within (124655) *(links to task and person)*
- **Policies and procedures:** Gaps in knowledge with regards to the application of the Guidance for Managing the Intoxication on Inpatient Wards policy (141835) *(links to task, person)*
- **Policies and procedures**: Requirements for hourly general observations do not require staff to physically go into the patient's room or to rouse the patient unless this has specially been indicated as part of their care plan (159260) *(links to person, task, internal environment)*
- **Organisation of work:** The allocation sheet for 21.08.2020 differed to the staff members who were actually undertaking observations. Two staff members had to escort a patient off the ward to the RLH at approximately 13.00hrs which resulted in the ward being two members of staff short, but the allocation sheet did not reflect this and was not changed. Staff members allocated duties on the allocation sheet differed to who carried out the observations. There was also no escalation of any staffing issues to the DSN although the ward manager confirmed at interview that staffing levels were adequate for the ward on this shift and were not a concern. and Handover sheet did not reflect changes to allocation sheet when two staff who were originally assigned observations had to escort a patient to a hospital appointment (132260) *(links to task, person, external environment, internal environment)*
- **Resource availability:** No bed availability on the older adults ward led to the patient being admitted to an adult acute ward (155136) *(links to task, person, internal environment).*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis -Organisation

Organisation

- **Staffing/skill mix:** Member of staff phoned in sick: The staff member called in at short notice had not completed ILS training (116848) *(links to person and task)*
- **Staffing/skill mix:** There was no senior Band 6 nurse on the night -shift (204370) *(links to person)*
- **Staffing/skill mix:** There is only one doctor on call covering all the wards at hospital X – the workload would become unmanageable if every NEWS sc ore of 2 or above is escalated (207916) *(links to person, task, internal environment and technology & tools)*
- **Staffing/skill mix:** Staff shortages & a busy ward linked to gaps in observations (170863) *(links to person, task, internal environment)*
- **Staffing/skill mix:** Additional staff not requested for nightshift (167593)*(links to person and task);*
- **Staffing/skill mix**: Bank members of staff, working nights only, who are not being regularly supervised in line with Trust policy (where gaps in t raining would have been identified; (specifically, BLS training for 141835, 199283 and ILS training for 116848) *(links to person and task)*
- **Staffing:** Staffing issues within the IPC team when the ward sought advice on treatment of a patient with scabies (209864) *(links to person and task)*
- **Staffing:** Staff member allocated emergency response had to go and work on another ward when another staff member did not turn up for the shift (107366) *(links to task, person, internal environment)*
- **Staffing:** There is no dedicated junior doctor on ward due to sickness and annual leave (159260) *(links to task, person, internal environment)*
- **Supervision arrangements:** Gaps in supervision of staff (141835) *(links to person and task)*
- **Work schedules/staffing/skill mix:** No consultant psychiatrist review because consultant on annual leave and consultant covering not asked to review patient (159260) *(links to person, internal environment and task):*
- **Work schedules:** Medical reviews of patient not carried out (159260) or patient was new to the ward and consultant review not yet carried out (155136) *(links to person and task)*
- **Work schedules:** Ward round scheduled at short notice and then overran; staff member attending the ward round was also responsible for carryin g out observations and omitted the observation (134929)*(links to task, person, internal environment)*
- **Work scheduling:** Member of staff named as responsible for overseeing falls risk assessment was completed was on jury service. No other staff member was assigned responsibility for the task in their absence (204370) *(links to task, person, external environment)*
- **Work schedules/staffing:** Bank staff members, working nights only: No process to assess their competences (e.g. BLS training)(141835) *(links to task & person)*
- **Workload allocation:** It was not clear who in team who was responsible for patients with physical health conditions (113911) *(links to person, task)*
- **Management system to oversee competencies**: Local observation register (which records which staff are up-to-date with observation competencies) is held for substantive staff only and not temporary staff (bank and agency staff). (141835) *(links to task and person)*

Figure 5: SEIPS maps summarising the themes from the contributory factors analysis - Organisation

Organisation

- **Training & Induction:** Staff member (bank band 3) allocated observations when they have not been trained in carrying out observations (118985) *(links to task & person)*
- **Training & Induction:** Systematic checks had not picked up that Bank band 3 had not been trained on carrying out observations (188985) *(links to task & person)*
- **Training & Induction:** Systemic issue that Bank staff do not routinely undergo induction, including required training for duties they may need to do as part of their role. (118985) *(links to task & person)*
- **Training & induction:** Staff (including bank staff and preceptorship nurses) not trained in ILS (116848) *(links to task & person)*
- **Training:** Gaps in VTE screening training (170863) *(links to person, task, and technology & tools)*
- **Training:** Ward staff were unaware to preserve defibrillator as evidence following CPR (107366) *(links to technology & tools, person, task)*
- **Training on physical health assessment** (171073; 141835): For example, HCAs not trained to understand snoring could indicate respiratory depression *(links to task and person)*
- **Training:** On CIWA assessment tool scoring and interpretation**:** (172230) *(links to technology & tools, person, task)*
- **Where new information is held:** Staff unable to update Rio with new patient details due to a lack of access rights to undertake this task (157482) *(links task, person and technology and tools)*
- **Where new information is held and how it is flagged:** Risk assessment was not updated: There is a function in Rio when documenting in the progress notes to flag specific risk information which then pulls the information across to the risk assessment document: This function was not utilised. (159260) *(links to technology & tools, person, task);*
- **Where new information is held and how it is flagged:** Blood pressure readings within the Rio progress records were not entered within the clinical portal client view, which gives an overview in a chart of all the patients' readings. (162980) *(links to technology & tools, person, task)*
- **Safety culture:** Atmosphere and culture on hospital wards is different at night, with fewer structured activities, an absence of visitors, no escorted leave or telephone contact. Medication rounds and meals end by 10.00pm, the majority of patients retire to their bedrooms, main lights are turned off and staff take longer breaks. (199283) *(links to person and internal environment)*
- **Safety culture:** Patient had been deemed unsuitable for an acute mental health bed 3 days prior to his transfer (157482) *(links to task, person and internal environment)*
- **Safety culture:** Shortcomings in observation practice have developed over time in the Trust. It is recognised that this is a long term, ongoin g initiative and the goal of consistent improvements in practice will take time to achieve. (172230), *(links to task, person, internal environment)*

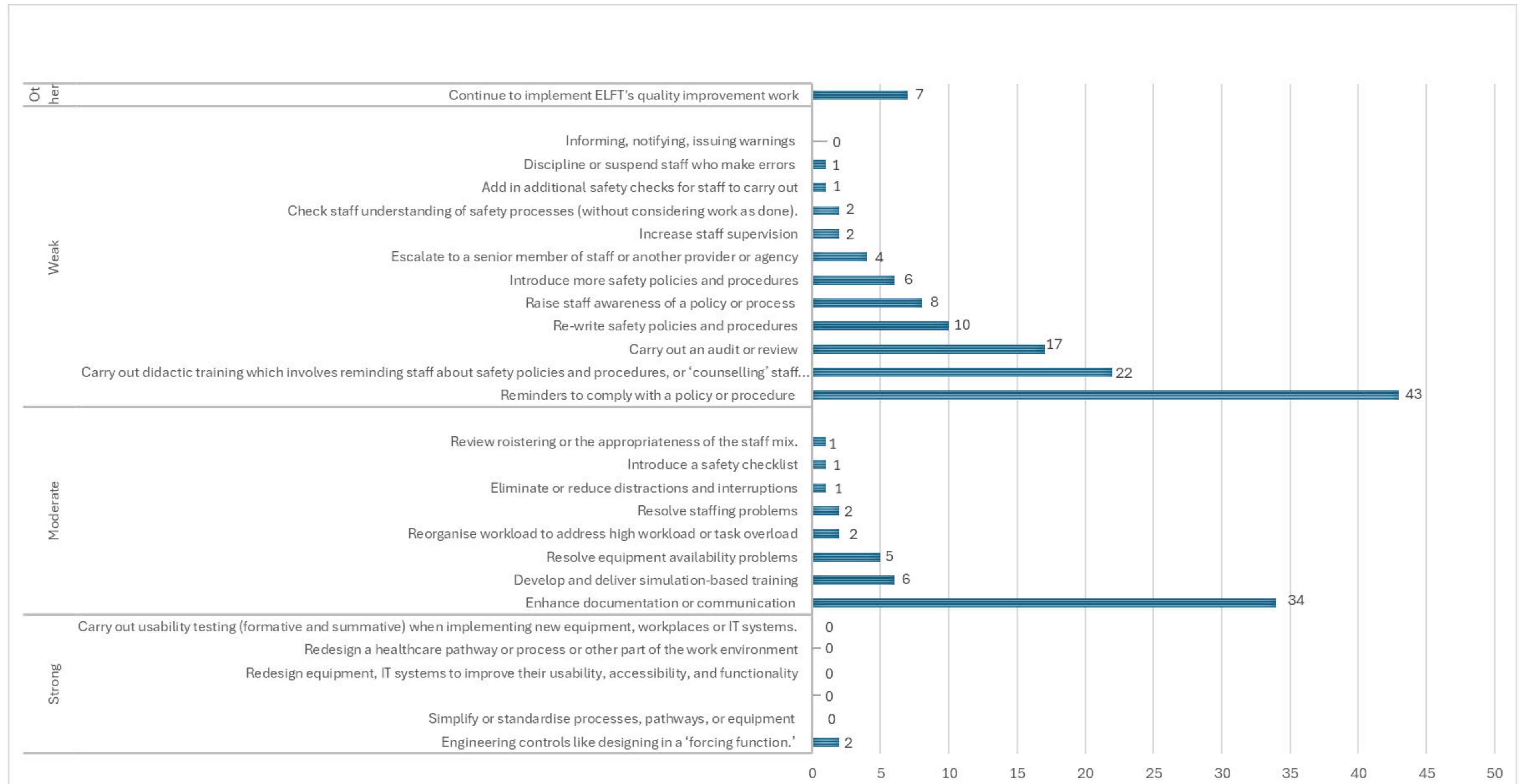
4.3 Strength of recommendation analysis findings

Figure 6 shows the strength of recommendations analysis findings for the twenty-six serious incident investigation reports included in the sample. There were one-hundred, and seventy-seven recommendations made across the twenty-six reports. One hundred and sixteen recommendations (i.e. 66%) were classified as 'weak,' fifty-two (i.e. 29%) were classified as 'moderately strong' recommendations, and two were classified as strong recommendations (i.e. 1%). An additional category of 'other' types of recommendations was created because the reports contained recommendations describing ELFT's on-going quality improvement work to enhance observations: Seven recommendations were categorised as 'other,' (i.e. 4%). All seven recommendations in the 'other' category described ELFT's on-going quality improvement work.

Figure 6 shows that the most frequently occurring type of recommendation was 'reminding staff to comply with a policy or procedure': The reports contained forty-three recommendations that were reminders to comply. The second most frequently occurring type of recommendation was, 'enhance documentation and communication': There were thirty-four recommendations in this category. The third most frequent type of recommendation was 'didactic training which involves reminding staff about policies and procedures or counselling staff about the way to deliver safe patient care,' (there were twenty-two recommendations in this category. The fourth most frequently occurring type of recommendation was 'carrying out an audit or review,' (seventeen recommendations). Rewriting safety policies and procedures was the fifth most common type of recommendation (there were ten recommendations in this category). Hence, four out of the top five most frequently occurring recommendations were 'weak, person-focused,' recommendations.

The profile of recommendations shown in Figure 6 is not unusual: The report author has carried out several similar types of analysis in other healthcare organisations. Universally, the findings show that serious incident investigation primarily comprise 'weak' person-focused recommendations, and very few strong recommendations. It is important to note that ELFT's profile is like other healthcare organisations. Previous research has identified that root cause analysis, the investigation methodology used NHS England's Serious Incident Investgation Framework, led to investigations that focused on fixing the person, rather than fixing the design of the healthcare systems. The weaknesses with root cause analysis prompted NHS England to abandon the SI Framework, introducing the Patient Safety Incident Response Framework (PSIRF) in 2022.

Figure 6: Showing the analysis of the strength of recommendations



4.4 Findings from the SEIPS Work System Explorer workshops

Appendix C summarises the insights into the work system for therapeutic and physical health observations from the six SEIPS Work System Explorer workshops and two one-to-one interviews with staff. The main findings are:

- Overall, the findings show how the task of carrying out observations (therapeutic and physical health) is embedded within a complex work flow on wards and PICUs: The quality and completeness of observations is influenced by multiple factors including other microsystems and tasks, for example, handovers, MDT meetings, ward rounds, admissions and discharges and escorted leave. Observations practice is also impacted by task distribution across the team, how observations are reallocated when unexpected events occur, staffing levels, the 'fit' between staff on shift and patient acuity, whether potential task conflicts are anticipated and managed, (e.g. holding the emergency response bleep whilst being allocated intermittent observations), team cohesiveness and culture, equipment functionality and availability, and how distractions and interruptions are handled. It is also impacted by dynamic changes on a ward or PICU, for example, staff responding to another incident, or a patient being stepped up to 2:1 observations midway through the shift.
- Ward and PICU staff adapt and 'trade off' the task of carrying out observations with other competing tasks, for example, taking patients on escorted leave, ward rounds, handovers, emergency response, admissions, discharges, following up referrals and hospital appointments, communicating with family members etc.
- Distractions and interruptions occur frequently when carrying out observations, including requests from patients and other team members, resolving equipment functionality and availability problems, admissions to the ward arriving later than scheduled and ward rounds taking place at short notice. In terms of equipment functionality, staff highlighted issues with BP monitors being broken, pulse oximeters with flat batteries and broken laptops.
- Wards with high numbers of admissions (e.g. Globe, Joshua), usually have more patients on intermittent observations because patients are put onto intermittent observations on admission. Staffing levels post-pandemic have not kept pace with the increasing admissions and flow of patients through wards, and this in turn, impacts workload.
- There are differences in team culture across wards, and within wards, across shifts. Team culture impacts on workload allocation, equitable treatment of bank staff, and the overall atmosphere on the ward.
- 'Work as done' varies from 'work as imagined' and 'work as prescribed' in key policies and procedures like the ELFT Observation Policy and Procedure. Staff shared examples of observation documentation being done at the end of the shift and of multiple intermittent observations being carried out the documentation being completed from memory. This has implications for audits which measure compliance with observations being documented: Audits measure the number of 'missed observations' using what is documented on observation sheets as the data source would not identify these types of workarounds.

- In terms of ‘work as done’ versus ‘work as imagined’ and ‘work as prescribed,’ staff described carrying out observations for hours at a time. Carrying out 1:1 or intermittent observations for hours at a time pushes staff to their performance limits.

4.5 Insights into ELFT’s three QI interventions from the workshops

As stated previously in the report, ELFT has been working on improving observations practice since 2021. A Trust-wide Quality Improvement programme which involved all fifty-four wards, their staff teams and service users across the Trust, and ran over a period of 18 months, was undertaken from September 2022, and led to three agreed interventions (board rounding, zonal observations and life skills workers on twilight shifts to carry out activities). The aim was to improve consistency of completed observations and shift the culture of observation practice. The three QI interventions are shown in Table 5. together with insights gained from the SEIPS Work System Explorer workshops:

Table 5: ELFT’s QI interventions, their impacts, ‘work as done,’ and Safety II learning

Improvement intervention	**Where it has helped**	**Work as done & Safety II learning**
Board relay- this idea is based on the concept of a baton relay – you never let go of the baton until you pass it onto the next person. The board relay is related to general observations and intermittent observations only and aims to reduce the risk of observations being missed and improve handover of clinical information between staff undertaking the observations	The Board relay has improved with handover of observations and accountability and responsibilities for carrying out observations. Before board relay was introduced, staff members would finish their allocated set of observations and leave the observations sheet in the nursing office for the next staff member to pick it up and take over the observations. Board rounding has introduced a formal handover of the board/observations task. Staff keep hold of the board until the staff member who is carrying out the observations for the next hour arrives, then you sign to show you have handed over responsibility for carrying out the observations to the other staff member, and they sign to confirm they have received the board. The patient’s care plan (or a bullet point summary of the care plan) is also attached to the board (i.e. risks, triggers and calmers). Staff on Rosebank ward, who tested the board relay intervention, have reported the ward feels safer, they feel more aware of what to do when carrying out observations and having a conversation about the needs of service users every time the board is handed over helps them to understand the current risks for each patient.	**Work as done** Some (not all) staff are reluctant to take the board relay board onto the ward with them because they are concerned it would be used as a weapon by patients. At times, staff do not take the observation sheet with them either and do a round of intermittent observations for several patients, then come back to the nursing office and complete the documentation from memory. Where a staff member is carrying out observations for several patients this increases the likelihood the documentation will be inaccurate. *‘The Board used for board rounding is sometimes left in the office – the observations are carried out and we then do a round of say, five sets of intermittent observations and we go back to the office and write on the observation sheet. Sometimes it is not safe to take the board onto the ward with you because our patients are sick, and this leads them to be aggressive. But I said {sic to a colleague the other day}, if you have done five intermittents in a row, how can you remember who was where and which observations are for which patient?’* **Safety II Learning** On some wards, Nurses in Charge and Band 6’s stand in the day area and role model the handover of the observations board for their team. By demonstrating how the board relay works, and ‘what good looks like,’ it helps staff who have joined the team after the intervention was introduced learn how to do the board relay. One ward manager described how she and two of her senior RMNs observe other team members doing the board relay, providing feedback to staff.

Improvement intervention	Where it has helped	Work as done & Safety II learning
Zonal observations- zonal observations allows an alternative method of observation, which involves designating the ward into different zones where allocated staff observe and engage with patients individually and as groups for set periods of time. This is to allow for continuous engagement with patients and monitor environment and patient dynamics over a 12hour shift. Zonal observations can be plotted against certain times or functions dependent on the ward layout and key tasks relevant to the service user group.	Zonal observations help wards to distribute staff and patients throughout the ward. Staff who participated in the SEIPS Work System Explorer workshops, described how zonal observations has, at times, led to a more even distribution of patients and staff throughout the ward. This in turn has reduced tensions that can build up when patients congregate in one part of the ward, for example, the day area. Positioning staff around the ward has also at times, led to more conversation between staff and service users. Staff described how zonal observations has, (in some cases), support on-going therapeutic conversations with patients.	**Work as done** A ward's ability to carry out zonal observations well depends on a combination of the patient mix on the ward (i.e. the person), the ward layout (i.e. internal environment) and the gender mix of staff working on the shift (i.e. the person). On some wards, corridors at the back of wards are blind spots. One ward described how on their ward, there are two male in-patients who have threatened female staff. When the team composition for a shift comprises mainly female staff, the NIC cannot organise zonal observations because it increases the risk female staff would be assaulted if they are asked to stay in the corridor at the back of the ward (which is where the two patients who have threatened female team members have their rooms). On another ward, team members described how there are female patients with a history of sexual trauma who cannot be observed by male staff. These patients can only have observations carried out by female staff. Where the gender mix of staff on the shift includes several male team members, it makes allocating all types of observations more challenging, and particularly zonal observations. NICs reported that if they see the gender composition of staffing for the shift will impact zonal observations, they phone around other wards and try to swap staff, but often it is not possible to switch team members across wards. **Safety II Learning** One workshop participant described how on his ward a 'buddying up' strategy is used: One staff member is assigned zonal observations; a second staff member also positions themselves on the same corridor. When a patient asks the

		person leading the observations to make them a drink, or fetch a parcel from the ward reception, the staff member will pass on the request to their colleague. Their colleague leaves the corridor to carry out the patient's request, thus enabling the staff member responsible for zonal observations to remain on the corridor. The 'buddying up' has had a positive impact on preventing requests from patients distracting staff who are leading observations.
Improvement intervention	**Where it has helped**	**Work as done & Safety II learning**
The third QI intervention is twilight shifts- this shift pattern adds an extra member of staff to requirements for a shift.	Concern about the lack of activities on mental health inpatient wards is long-standing. Research shows that in-patients receive insufficient access to a range of activities and report high levels of boredom. The twilight shift QI intervention was introduced in response to periods where there is reduced structured activity (after 5PM). It covers the early part of a night shift. Staff undertaking these shifts lead on offering therapeutic interventions in the form of activities to service users on the ward.	**Work as done** Staff who participated in the SEIPS Work System Explorer workshops repeatedly described how staffing, skill mix, acuity, and workload impact on a ward's ability to carry out activities with patients. Unlike the other two QI interventions, workshop participants did not volunteer examples of how an additional staff member working the twilight shift had helped increase structured activities on the ward after 5pm. Rather, in every workshop, staff described how workload demands, coupled with staffing and skill mix challenges, left staff feeling exhausted and, at times, with a sense that they could not provide the level of care to patients they wished to provide. Staff described how the pressure on a shift builds hour-by-hour. Participants shared examples of where they could not meet patients' requests for activities. For example, one participant described how on the previous day's shift, two patients had asked if they could play snooker and another group of patients had asked if they could watch a movie, but the staff struggled to meet these requests because the observation, escorted leave and other workload demands meant there were insufficient numbers of staff on duty to oversee these activities.

5.0 Reflections and next steps

ELFT has already carried out significant work on improving therapeutic and physical health observations. The report author makes four final reflections based on the analysis:

1. The design of the therapeutic observation task shapes human behaviour to locate each patient – the task design is to carry out a 'whereabouts observation', rather than engage in therapeutic care. To improve observation practice, we therefore need to redesign the work system. For example, the SEIPS maps, developed as part of the human factors analysis, highlight a general theme around the conceptualisation and design of the task of therapeutic observations: Observation sheets (i.e. the technology & tools) comprise codes which staff complete when carrying out observations to document each patient's whereabouts. This shapes staff behaviour, so observations are not therapeutic engagement with patients. They are a noting down of the patient's whereabouts at a given point in time. Additionally, naming the task, and associated policies, procedures, and artefacts (i.e. the observation sheet) 'observation' shapes staff behaviour in ways that do not foster therapeutic care.
2. As expected, the human factors analysis has identified disconnects between 'work as prescribed,' 'work as imagined,' and 'work as done.' Going forward, there is a need to focus improvement work on reconciling these disconnects: This means reducing the 'turbulence' in the work system created by the multitude of factors identified in the report.
3. The QI interventions of board rounding and zonal observations address some, not all, of the factors which lead to observations being missed, and falsification of observations. The report author acknowledges the interventions were never designed to address the multitude of factors identified in this report.
4. The findings of the report, particularly those from the SEIPS Work system explorer workshops, highlight the limitations of the current approaches to monitoring observation practice. Audits of compliance with documenting observations and audits which involve ward managers carrying out spot checks of observation sheets which are then plotted on an SPSS chart to give a % compliance measure of missed observations may not reflect 'work as done.' They measure, 'observation documentation.' Such measures do not give insights into how observations are performed, and the trade-offs and adaptations staff make when carrying out observations.

As a Human Factors Professional, the report author does not make recommendations without including end-users in their design and content. The next steps are therefore:

- For senior leaders at ELFT to consider the findings and implications of the report alongside other work being undertaken to improve observations practice.
- To develop a shared plan of the way forward, with a focus on where we can improve the work system, redesign tasks, and reconcile the gap between 'work as imagined,' 'work as prescribed,' and 'work as done' highlighted in the report.

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Appendix A: Breakdown of serious incident investigation reports by ward and ward type

Number	SI number	Ward	Type
1		Ivory	Adult in-patient acute (female)
2		Coral	Adult in-patient acute (male)
3		Onyx	Adult in-patient acute (male)
4		Roman Ward	Adult in-patient acute (female)
5		Topaz	Adult in-patient acute (male)
6		Poplars	Older adult in-patient acute
7		Ash	Adult In-patient acute (male)
8		Emerald	Adult in-patient acute (female)
9		Ivory	Adult in-patient acute (female)
10		Townsend Court	Adult in-patient acute (female)
11		Ash	Adult in-patient acute (male)
12		Opal	Adult in-patient acute (male)
13		Crystal	Adult in-patient acute (female)
14		Gardner	Adult in-patient acute (female)
15		Coral	Adult in-patient acute (male)
16		Emerald	Adult in-patient acute (female)
17		Bevan PICU	PICU
18		Topaz	Adult in-patient acute (male)
19		Opal	Adult in-patient acute (male)
20		Poplars	Older adult in-patient acute
21		Brett ward/St Mungo's hostel	Adult in-patient acute (male)
22		Lea ward – died at RLH	Adult in-patient acute (male)
23		Lea Ward	Adult in-patient acute (male)
24		Loxford ward	Low secure rehabilitation unit (forensics)
25		Ludgate ward	Medium secure rehabilitation unit (forensics)
26		Willow ward	Adult in-patient acute (female)

Appendix B: Seven steps to carrying out a SEIPS Work System Explorer workshop

Workshops were structured as follows:

Step 1: Creating psychological safe space for the conversation. The report author facilitated the workshops so that participants shared something about themselves that was non-work related, and we set our shared expectations for the conversation. For example:

- if someone else has a different perspective or experience to our own, their view is valid and enables us to learn how others experience the world.
- Everyone’s voice and viewpoint has equal value, irrespective of professional background, and level of seniority.
- Listen with intent, making sure our focus is on the person who is sharing their insights.
- Being open takes bravery.
- Remember some of us are extroverts, some of us are introverts: Collectively, let us make space to ensure everyone feels able to share.

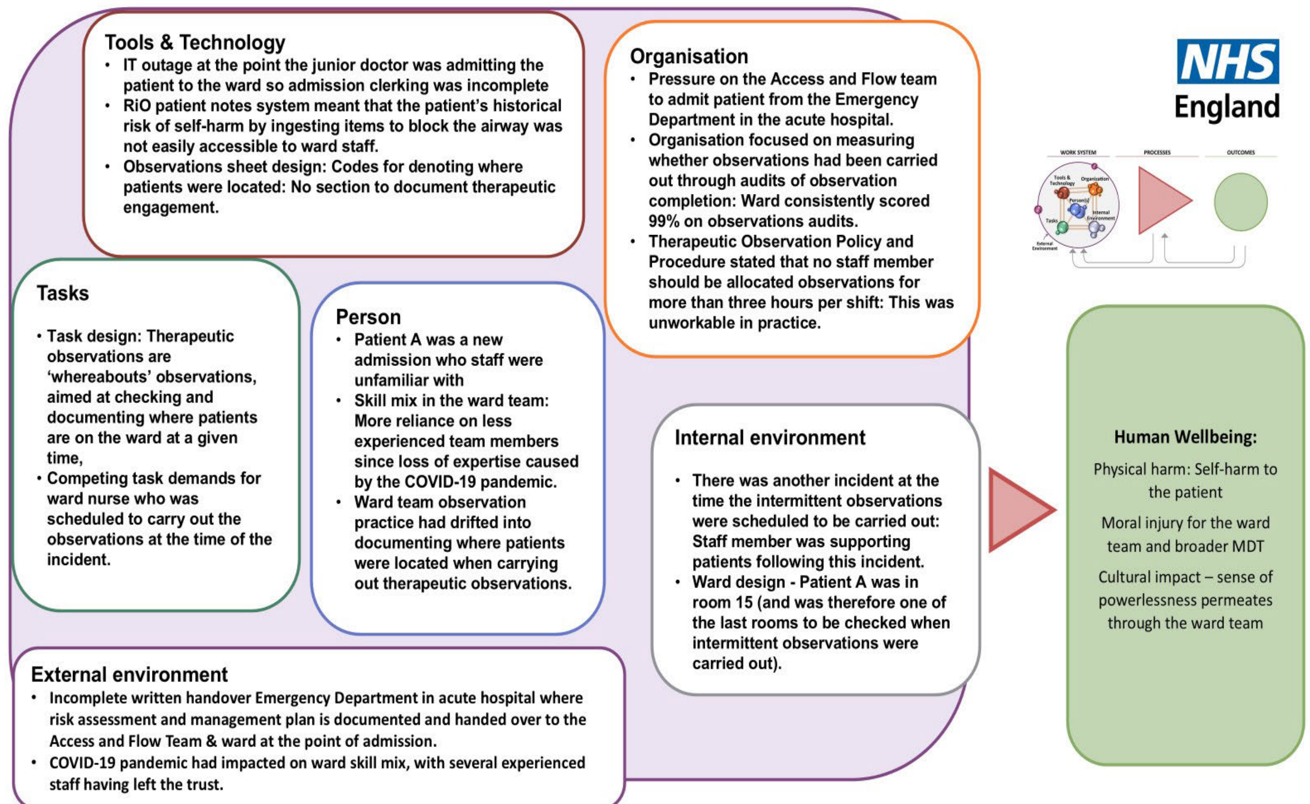
Step 2: Introduction to the Patient Safety Incident Response Framework

This focused on setting the scene for the workshop by explaining the transition from the SI Framework to PSIRF, what is meant by ‘work as done,’ and how PSIRF brings with it a shift from person-focused recommendations to system-focused safety actions.

Step 3: Introducing SEIPS through storytelling

A mocked-up patient safety incident story was used to illustrate the elements of the work system in the SEIPS model (see Figure 4). Introducing SEIPS through storytelling helps healthcare staff connect with what is otherwise a very abstract human factors model. Storytelling makes SEIPS accessible. The patient safety incident related to a patient who self-harmed whilst on intermittent observations. The story of the incident was described through the lenses of the SEIPS work system, describing how factors in the technology & tools, task, organisation, person, internal environment, and external influences interacted to lead to the incident. The outcomes were described both in terms of the physical harm to the patient involved, and importantly, the cultural and moral harm to the ward team caring for the patient. Describing the different types of harm experienced by those affected (i.e. patients, families, and staff involved and who are part of the broader MDT) widens staff understanding of harm. It also reassures staff that when we learn from patient safety incidents, we are considering broader types of harm, not solely focusing on physical harm (although this is of course important).

Figure B1: SEIPS storytelling example used in the workshop



Step 4: Introducing the SEIPS Work System Explorer

The facilitator then introduced the SEIPS Work System Explorer, asked participants to read it and then working in trios or pairs, to 'share the challenges/pain points you face when carrying out therapeutic and physical health observations on your wards.' NB for the virtual workshop a group forum conversation was carried out at this stage of the workshop.

Step 5: Sharing experiences and insights into the work system

Workshop participants then shared their insights into pain points and challenges in the work system. Notes were taken by the workshop facilitator. Where participants shared how specific tasks are carried out, for example, physical health observations, intermittent observations, the facilitator used 'talk throughs' to get a deeper understanding. By 'talk throughs,' we mean the facilitator prompted participants to 'talk us through how you do task A,' or 'walk me through the steps in process B.'

Step 6: What happens when things work well?

In the next part of the workshop, staff were asked to share what facilitates observations going well. Notes were taken by the workshop facilitators.

Step 7: Readback to confirm a shared understanding and thank-you

In the final part of the workshop, the workshop facilitator used the ‘readback’ technique to confirm she had captured what had been shared accurately. Workshop participants were then thanked for their time and participation.

Appendix C: Insights into the work system for therapeutic and physical health observations from the SEIPS Work System Explorer workshops.

Element of the SEIPS work system	Insights into 'work as done'
Technology and tools	Challenge of equipment availability and workability when carrying out physical health observations: Laptops are slow, monitors are sometimes not working, equipment is sometimes not charged. For example, pulse oximeters and BP machines are broken so staff allocated physical health observations must search to find equipment that is working.
Technology and tools	Board rounding helps with handover of observations and accountability. Before the board rounding was introduced, staff members would finish their allocated set of observations and leave the observations sheet in the nursing office for the next staff member to pick it up and take over the observations. Board rounding has introduced a formal handover of the board/observations task. Staff keep hold of the board until the staff member who is carrying out the observations for the next hour arrives, then you sign to show you have handed over responsibility for carrying out the observations to the other staff member, and they sign to confirm they have received the board. The patient's care plan (or a bullet point summary of the care plan) is also attached to the board (i.e. risks, triggers and calmers).
Technology and tools/Organisation	*'When we are short of staff it becomes very difficult to manage the workload when equipment we need is broken, and we waste time searching for kit that is working…it's an added pressure on a pressured shift.'*
Technology and tools/person/task	Some staff carrying out intermittent observations will not take the board rounding board onto the ward with them because they are concerned it would be used as a weapon by patients. At times, staff do not take the observation sheet with them either and do a round of intermittent observations for several patients, then come back to the nursing office and complete the documentation from memory. Where a staff member is carrying out observations for several patients this increases the likelihood the documentation will be inaccurate. *'The Board used for board rounding is sometimes left in the office – the observations are carried out and we then do a round of say, five sets of intermittent observations and we go back to the office and write on the observation sheet. Sometimes it is not safe to take the board onto the ward with you because patients are sick, and this leads them to be aggressive. But I said, if you have done five intermittents in a row, how can you remember who was where and which observations are for which patient?'*

Element of the SEIPS work system	**Insights into 'work as done'**
Technology and tools	Monitors used when carrying out physical health observations must be rolled to the patient's room. '*We don't feel safe using it because of the acuity of patients we have on the ward: Some are very unwell, aggressive, will use the equipment to harm themselves and others..'*
Technology and tools	Crystal ward use the following traffic light system: • Green to denote patients who are ready to be stepped down from the ward • Amber: for patients who are well. • Red: For patients who are unwell and/or who have physical health needs which require a lot of intervention. For example patients who have diabetes. The traffic light system fosters conversations about how patients are and information sharing about their physical health needs and the level of risk. It is helpful if staff have not been on shift for a few days because it helps them to understand what has happened since their last shift
Technology and tools/person	Bank staff access to Rio: Some bank staff are unable to access Rio before they commence the first set of observations on patients. And where they have not received a handover, they are observing patients without knowing the risks and triggers specific to that patient.
Technology and tools/organisation/person/task	*'We have patients on clozapine who need physical health observations carried out regularly, but sometimes the BP machines do not work and/or there are no batteries available so we cannot change the batteries in the pulse oximeters…'*
Technology and tools/organisation/person/task	Bank staff are sometimes allocated patients where the risk assessment and handover is incomplete or there is no handover: This means they are carrying out observations without knowing the risks or physical health condition of the patients they have been assigned.

Element of the SEIPS work system	Insights into 'work as done'
Technology and tools	Portable devices to record E-Obs are not available on wards. At times, the physical health observations are taken and then staff go back to the nursing office to record them, only to find another staff member is using the computer.
Technology and tools/Person	Availability and positioning of PCs on Joshua ward: Two PCs are positioned at the nursing station. The new ward administrator sits in the seat on the PC at the back of the nursing station, meaning the Nurse in Charge must use the PC which is situated at the front of the nursing station. The NIC is then distracted and interrupted throughout the shift when sitting at this PC – with questions from patients, team members etc. The distractions and interruptions caused by the positioning of the PC at the front of the nursing station makes it more difficult to keep apace of who is doing what, including observations, re-prioritisation of work depending on dynamic changes throughout the shift etc..
Technology and tools	Allocation sheet: The Allocation Sheet sets out the tasks allocated to staff members throughout a shift. The Allocation sheet, at times, needs to be amended throughout the shift to keep pace with changing conditions – for example, escorted leave, incidents on the ward etc.. (i.e. dynamic changes in the work system which impact on the allocation of tasks across the team). Allocation sheet: Does not reflect the dynamic nature of the work environment. Allocation sheet: The positives are that it sets out the tasks allocated to each staff member for the shift so there is clarity of roles and responsibilities. The negatives is that some team members will only do the tasks allocated to the on the allocation sheet
Technology and tools	E-Obs: There is poor network connectivity on wards so technological solutions like E-Obs need to be implemented alongside improved network connectivity.
Technology and tools	Some wards do not have laptops that work, others do. Where a laptop is broken or there is no hand-held device, tasks like Dialog+ take longer to complete. Staff must print out Dialog+, take the print out to the patient's room, have the Dialog conversation, and then type what has been recorded on paper from the conversation with the patient into Rio. Because there are so few PCs, staff then must wait before they can type the Dialog+ conversation into Rio. Whilst waiting, there are other tasks that need to be carried out – there is no time to wait around for a PC to become free, and this increases the risk that the documentation will be omitted.

Element of the SEIPS work system	Insights into 'work as done'
Technology and tools/external influences	When laptops are broken and need repairing the repair time is long – the trust has a contract with an external contractor. The lead in time for the contractor to complete repairs of laptops is long, meaning that wards have periods of time where there are fewer laptops available on the ward. This has a snowball effect on the documentation of observations – unavailability of laptops and few PCs on wards means the documentation of physical health observations is set aside whilst other tasks are completed.
Technology and tools/task	The requirement to submit an In-Phase report every time a 15-minute observation is missed adds additional workload, and at times, can have a knock-on effect on staff's ability to keep pace with intermittent observations.
Technology and tools/task	'Work as done' is that documentation is sometimes carried out at the end of the shift on some shifts.
Organisation/person/task	Bank staff are sometimes left for hours and hours doing 1:1s for patients in seclusion. They reported that when this happens, their attention drifts because they are human beings and cannot maintain focus. On some, not all wards, there is an unfair division of tasks, with permanent staff sitting back and letting bank staff do the work. This includes therapeutic and physical health observations. There are some NICs who favour their own staff over bank staff, so there is no equity in the division of labour. Bank staff cannot speak up and challenge because they are concerned they will not be booked by a ward manager for future shifts if they speak out. Note there are other wards where excellent working relationships between permanent staff and bank staff: Bank staff shared that on some wards (e.g. Rosebank) they are treated as valued and equal members of the team.
Organisation/task	Wards with the highest number of admissions (e.g. Globe, Joshua) in the trust, usually have more patients on intermittent observations because they are put onto intermittent observations on admission. Allocation of staffing needs to reflect the ward admission rate which is linked to higher workload mental health observations.
Organisation/task	Staffing levels per shift have not changed in response to the increased number of admissions following the pandemic: At times, the workload is unmanageable.

Element of the SEIPS work system	Insights into 'work as done'
Organisation/external influences	It is not unusual for new admissions to arrive in the evening towards the end of the day shift. One ward cited an example of two admissions both arriving at 7pm the previous week. Ward Managers agree an admission time with the Access & Flow team of 3 -4pm, then delays occur in the patient's admission journey, and this means patients arrive on the ward later than planned: This impacts on the admission experience of the patient, clerking the patient into the ward, and creates additional task workload at a time on a ward which is already busy. It causes the staff to have to adapt and re-prioritise tasks which in turn can disrupt the completion of therapeutic and physical health observations, and the accuracy of the documentation.
Organisation/person/ task	The monotony of carrying out therapeutic observations hour after hour is tiring: If the shift is working with one ST short, staff become tired because the reorganisation of the workload pushes them to their performance limits.
Organisation/person/ task	Blanket decisions are sometimes made in response to identified gaps in care which create additional pressures and task workload. For example, one ward cited an example where a Physical Health Nurse had been reviewing patient charts and identified a patient with a NEWS score of 2-3 who had not been escalated by the Bank Social therapist who had taken the physical health observations. The Physical Health Nurse then informed the Ward Manager that Bank Social Therapists must not carry out physical health observations. Decisions like this create additional pressure because the tasks then must be reallocated to permanent team members. The Ward Manager felt that a better solution would be to support Bank STs to understand the escalation process for physical health observations and then test their competences.
Organisation/person/task	There are variations across wards in terms of who carries out tasks like escorted leave and holding the emergency response bleep. For example, on Roman ward, escorted leave is mainly carried out by STs, and this can create task overload when an ST is assigned mental or physical health observations. On other wards, the RMNs help with the escorted leave.

Element of the SEIPS work system	Insights into 'work as done'
Organisation/person/ task	For Ward Managers orienting bank staff to the ward adds to their workload and puts an additional pressure on them which can take their attention away from physical and mental health observations. For some, not all, ward managers, a shift works better without bank staff because of the additional workload involved in their orientation to the ward. NB this does not apply where a bank staff member has worked on the ward previously.
Organisation/person/ task	Night shift staffing levels impact on the quality of observations we carry out, especially if there are team members who are (i) on emergency response duty, (ii) are female on a male ward where some of the male patients pose a risk to them, (iii) when anyone goes on their break.
Organisation/person/ task	Task conflicts occur when a staff member is allocated observations and is also allocated as a member of the emergency response team. 'Work as imagined' is that staff members will hand over the observations to the shift coordinator if the bleep goes off and they must respond to an emergency. 'Work as done' is that the staff member is responding to an emergency and the reality is handing over the observations gets missed in this scenario.
Organisation/Task	Therapeutic and physical health observations are interconnected with other processes and tasks: When improvement work focuses on either therapeutic or physical health observations in isolation rather than understanding their interconnectedness with other processes like rostering, risk assessment, shift handover, huddles, the MDT meeting, and how evolved the culture of therapeutic engagement with patients on a ward, the impact of improvement work is limited. For example, in the morning huddle, if information on a patients risks, the reason they are on a set frequency of mental or physical health observations is shared across the team at the morning huddle, then you set the staff member carrying out the observations up to succeed. If not, time is spent chasing information on the rationale for a patient being on the level of observations they are on. Another example is ward rounds: On Ward X, ward rounds take place on a Monday, Wednesday , and Friday. Ward rounds increase the workload, and the staffing level on these days is the same as on other days of the week. Sometimes simultaneous ward rounds are carried out and the nurse in charge is unaware a ward round will be carried out at that time. The nurse in charge needs to be on the ward round so they keep apace of the decisions being made and the tasks that need carrying out following the ward round. *'As nurses in charge, we often do not know what time ward rounds are going to happen. We used to have a consultant psychiatrist who would let us know the day and time, but other consultants tell us it is not possible for them to give us the heads up on the time of the ward round. The doctors work in the community, so it is difficult for them to plan a time..'*

	'Work as imagined is that we should invite family members and carers to ward rounds. But this is difficult when we don't know the time the ward round is going to be carried out… this impacts on observations is -physical and mental health -because family members know the patient best -they know what works and does not work, they know how the patient will self-harm, they know the physical health problems. And they have lives and jobs; it is just not possible for them to come at short notice to a ward round…'
Organisation/Task	Observations (mental health and physical health) interface with and are impacted by other task demands. For example, on Globe ward there are fifteen patients - most have escorted leave twice per day. Safe staffing levels are two RMNs and three STs: The interaction between the competing tasks of ensuring patients get escorted leave and carrying out observations at the set frequency.
Organisation/external influences	Access and flow pressures mean that patients who should be on PICU are admitted to adult acute in-patient wards. There is an indirect impact of the task of observations – one very sick patient can subsume a team's attention and other tasks, like documenting the observations or carrying them out at the correct time, get missed.
Internal environment	Design of wards: Current design of wards means they are not therapeutic environments. For example, on every ward there are blind spots, or the layout of the ward presents staff with challenges for carrying out mental health observations. For example, on Ward X, the corridor at the back of the ward is a blind spot. There are a couple of in-patients who are sexually disinhibited and so the NIC cannot allocate observations to female staff members because this would put them at risk of being assaulted.

Element of the SEIPS work system	Insights into 'work as done'
Internal environment	Wards are not designed as therapeutic environments: On one ward the team described a sensory room had been built next to the seclusion room: This means patients with autism, for example, were in a sensory room next to unwell patients on 1:1 observations or in seclusion.
Internal environment	On Joshua ward, a TV has been positioned in the back corridor of the ward. This was installed to distribute patients throughout the ward because there was previously a concentration of patients in the TV and dining area. Installing the TV in the back corridor has helped reduce tension from too many patients congregating in one area, but it has knock on effect for mental health observations. Staff must find patients at the back of the ward, and it has increased the risk to female staff, some who have been put at risk of being assaulted when carrying out observations on in-patients who exhibit sexually inappropriate behaviour.
Internal environment/Task	Staff who are allocated to carry out intermittent observations, walk around the ward looking for the patients who are on intermittent observations. There are numerous distractions and interruptions caused by requests from other team members and patients.
Internal environment/Task	High task workload means that staff find it challenging to spend time carrying out activities. For example, on one ward the previous day's shift, some patients wanted to play a game of snooker, and a group of other patients wanted to watch a movie. Each activity needs a staff member to be present, but the workload prevents this being possible.
Internal environment/task/ person	Distractions and interruptions are a problem for staff carrying out observations. For example, one staff member was doing intermittent observations when they were asked to make the beds up for two new admissions who were due to arrive on the ward. They were due to go on their break after carrying out the next set of intermittent observations when the request to make up the beds was made. It is not physically possible to make up two beds within the time between sets of intermittent observations, and there was no-one else to delegate the task to…this is when prioritisation becomes tricky. *'Too many tasks to do at the same time, getting interrupted so you lose your mental focus on which intermittent obs., you have to do next..'*

Element of the SEIPS work system	Insights into 'work as done'
Internal environment/task/ person	Zonal observations are helping a lot (Crystal ward). We position staff across the ward – if a patient asks someone doing the observations to make them a cup of tea, they ask a colleague to make the patient's drink, and this prevents them from being distracted from the observation task. Zonal observations mean you put staff on a corridor, and this improves their interactions with patients. The staff member responsible for carrying out the observations does not leave the corridor but has a second staff member who they can call for help with other tasks.
Internal environment/task/ person	'Work as done' is that patients ask the person carrying out the observations to make them a drink or for a glass of water or to do something for them. Time elapses and observations get missed because staff are being responsive to requests from patients.
Task	The new handover system has created additional documentation workload for physical health observations: Staff record the observations on Rio, on the physical health chart, and on the handover system.
Task/person	It is a challenge to keep a pace with the workload if you have three patients who need their physical health observations taken every four hours: There are numerous distractions when taking physical health observations.
Task/person	Sometimes staff on some wards spend five hours back-to-back carrying out intermittent observations. The ward teams know they are not complying with ELFT's Observation and Engagement policy and procedure, but staffing constraints, the number of patients on intermittent observations and patient mix, together with the staff gender mix means that the aspirations in the Observations policy and procedure are not workable in practice.
Task/person	The observation task is currently designed for staff doing intermittent and general observations to simply record a patient's whereabouts at a point in time. The task is not designed to support therapeutic engagement.
Task	On ward X there are two patients on 1:1 observations and five patients on intermittent observations. Seven patients are due escorted leave. Staff must facilitate escorted leave because it creates a more relaxed atmosphere on the ward.

Element of the SEIPS work system	Insights into 'work as done'
Task/external influences/person	High number of out of area admissions mean staff spend a lot of time trying to troubleshoot community care arrangements, out of area patients often do not have a care coordinator and sometimes community teams will not accept them as patients, which delays their discharge, and they start to lose hope for the future.
Person	Team dynamics: Where the team members on shift show they are anxious and worried how they will manage the workload; this permeates the atmosphere on the ward. Leaders who create a relaxed, confident vibe amongst their team diffuse this and it has a positive impact on the ward atmosphere. Team dynamics: Some (not all) team members stick to the tasks they are given on the allocation sheet and do not step in and help other colleagues who are overloaded. There are no sanctions for team members who are not team players. Other team members take the initiative and step in and help when they can see their colleagues are overloaded. When this happens, the staff member allocated the task on the Allocation Sheet may not always match the staff member who has carried out the observation and signed it has been done. There is also a scenario whereby a staff member steps in to help another staff member who is busy but has been allocated intermittent observations and the staff member who signs the observations sheet is different from the staff member who has carried out the observation: Staff are adapting to support busy colleagues, but are also aware that the signature on the observation sheet needs to match the allocation sheet. Hence the staff member allocated to do the observation signs for it. *'Yesterday the ward was so busy, and we were blessed with staff who were willing to pull together and help…'* Patients: When patients make requests of staff who are carrying out other tasks like mental and physical health observations, they want the staff member to respond immediately There is a perception amongst staff that patients are more on edge on Mondays and Fridays.

Element of the SEIPS work system	Insights into 'work as done'
Person	STs – at times we go home drained after a shift. We have no energy left and our body just wants to shut down.
Person	If a patient is put on 2:1 observations part way through a shift, this impacts on staff who are allocated observations and is another factor which contributes to staff having to do observations for several hours without a break.
Person/task	Physical health observations – we have a schedule for how frequently they need to be carried out but we do physical health observations in the morning so the doctors are around and can view the results.
Person/Task	Staff can spend three hours or more on 2:1 observations: This is mentally exhausting because it is three hours plus with a patient who is self-harming or aggressive.
Person/Task/internal environment	Intermittent observations: It is difficult to keep to the scheduled time because every patient on intermittent observations wants to have a conversation with the staff member who comes to check on them. This, together with the travel time around the ward locating patients, means that 15 minutes has elapsed, and the next set of observations are due. At times, the pressure of finishing one set of intermittent observations and starting the next set means that the documentation gets missed or observations are carried out later than scheduled.
Person/Organisation	Patient mix: One ward (Emerald) described how they have two female patients on the ward who assault male staff members, so only female staff can be allocated observations for these two patients. But at times, the team on the shift is four male and three female staff and that presents challenges in ensuring the female staff are not continuously allocated observations – makes it difficult to follow the Observation Policy and Procedure, particularly the limits on how long staff should be doing observations. This situation is escalated to the DSN, and requests are made to swap male staff for female staff, but this is not always possible.
Person/internal environment	Distractions and interruptions caused by patients fighting on the ward (Crystal PICU) draws attention away from observations and documenting them.