SPSP Acute Adult Programme Deteriorating Patient Change Package 2023

Extended version with resources

Introduction

Background

This publication is the latest version of the Scottish Patient Safety Programme (SPSP) Deteriorating Patient change package, first published in 2021. This update has drawn on the latest evidence and guidance including SIGN 167 Care of Deteriorating Patients guideline (June 23). The change package provides an evidence-informed resource to support teams with improvement in the early recognition and structured response to patient deterioration.

Overview

The **main driver diagram** page includes a National aim, Primary Drivers and Secondary Drivers.

Each **primary driver** is broken down to include **secondary drivers** and associated **change ideas**.

Evidence, guidelines, tools, and resources are included for each secondary driver.

Additional resources available on our website:

- Shorter version without tools and resources
- Accessible version with tools and resources
- Measurement framework

This is an interactive document.

Clicking the **home icon**  will return you to the main driver diagram.

Clicking the **arrow icon**  will return you to the primary driver associated with that section.

Deteriorating Patient Driver Diagram 2023

Healthcare Improvement Scotland | Every Person Every Time 24/7 Scottish Patient Safety Programme

What are we trying to achieve…	We need to ensure…	Which requires…
A reduction in Cardiopulmonary Resuscitation rate, in acute care, by March 2024	Person-centred care	Shared decision making* Person centred care planning Future care planning Treatment escalation planning
	Recognition of acute deterioration	Use of NEWS2 and clinical judgement Action on patient, family, or carer concern Identification of people at higher risk of deterioration
	Standardised, structured response and review	A structured response to deterioration Senior clinical decision maker review Regular review and reassessment
	Safe communication within and between teams*	Interdisciplinary teamwork and collaboration Safe transitions in care Psychological safety to support escalation of concerns
	Leadership to support a culture of high quality care and patient safety*	Visible leadership at all levels Safe staffing* and resources to enable delivery of safe care System for learning* to support continuous improvement Staff wellbeing

Essentials of Safe Care

Primary Driver

Person centred care

Secondary drivers	Change ideas				
Shared decision making (SDM)	Use of 'what matters to you' approach to plan and deliver care	A shared decision-making approach is used for all care discussions	Early involvement of those close to the person including care partners, families, Power of Attorney/Guardians	Process for engaging current specialist and community teams involved in the person's care	Reliable SDM is supported by health literacy tools, a range of communication aids and independent patient advocacy
Person centred care planning	Existing complex care plans, e.g. patient passports, used to inform acute care planning	Early understanding of person's usual baseline, and presentation when unwell/deteriorating	Care planning includes clinicians, carers and teams who have expertise about a person's needs	Post-acute illness follow-up conversations with recovering patients, their family, and carers	Person centred discussions consider cultural or other diverse needs
Future Care Planning	Care teams access future care plan e.g. digital ReSPECT on admission and other interfaces	Use of framework to support discussions e.g. REDMAP	Iterative planning in acute setting informs updates to future care plan during hospital stay and at discharge	Information available to support people creating new Future Care Plans in acute care	Use of citizen-facing technology to support person held care plans e.g. via the Digital Front Door
Treatment escalation planning (TEP)	Locally agreed criteria for completion of person centred TEP	Locally agreed processes for future care plans to inform, and be informed by, TEP discussions	Processes support timely person centred planning by person's own care team to guide decision making out of hours		

Primary Driver
Person-centred care

Secondary Driver	Change ideas				
Shared decision making (SDM)	Use of 'what matters to you' approach to plan and deliver care	A shared decision-making approach is used for all care discussions	Early involvement of those close to the person including care partners, families, Power of Attorney/Guardians	Process for engaging current specialist and community teams involved in the person's care	Reliable SDM is supported by health literacy tools, a range of communication aids and independent patient advocacy

Evidence and Guidelines:

- Gans EA, van Mun LAM, de Groot JF, et al. Supporting older patients in making healthcare decisions: The effectiveness of decision aids; A systematic review and meta-analysis. Patient Educ Couns. 2023;116:107981
- Pel-Littel et al. Barriers and facilitators for shared decision making in older patients with multiple chronic conditions: a systematic review. BMC Geriatr. 2021;21:112.
- Realistic Medicine. What Realistic Medicine is and what it isn't. 2024.

Tools and Resources:

- Scottish Government. Realistic Medicine – National toolkit for professionals. 2024.
- Healthcare Improvement Scotland. What matters to you? 2021.
- NHS Education for Scotland (NES). Think capacity think consent. Supporting application of the Adults with Incapacity (Scotland) Act (2000) in Acute General Hospitals. 2017.
- NHS Education for Scotland (NES). Shared Decision Making. 2022.
- NHS Inform. Communication and involving you. 2023.

Primary Driver
Person-centred care

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Person centred care planning	Existing complex care plans, e.g. patient passports, used to inform acute care planning	Early understanding of person's usual baseline, and presentation when unwell/deteriorating	Care planning includes clinicians, carers and teams who have expertise about a person's needs	Post-acute illness follow-up conversations with recovering patients, their family, and carers	Person centred discussions consider cultural or other diverse needs

Evidence and Guidelines:

- Islam Z, Pollock K, Patterson A, et al. Thinking ahead about medical treatments in advanced illness: a qualitative study of barriers and enablers in end-of-life care planning with patients and families from ethnically diverse backgrounds. Health Soc Care Deliv Res. 2023;11(7):1-135.
- Pearse W, Oprescu F, Endacott J, Goodman S, Hyde M, O'Neill M. Advance care planning in the context of clinical deterioration: a systematic review of the literature. Palliat Care. 2019;12:1178224218823509.

Tools and Resources:

- NHS Education for Scotland (NES). Equality and Diversity zone.
- NHS Education for Scotland (NES). Once for Scotland: Learning Disabilities.
- NHS Education for Scotland (NES). Person-centred resources.

Primary Driver

Person-centred care

Secondary Driver	Change ideas				
Future Care Planning	Care teams access future care plan e.g. digital ReSPECT on admission and other interfaces	Use of framework to support discussions e.g. REDMAP	Iterative planning in acute setting informs updates to future care plan during hospital stay and at discharge	Information available to support people creating new Future Care Plans in acute care	Use of citizen-facing technology to support person held care plans e.g. via the Digital Front Door

Evidence and Guidelines:

- Scottish Government. Digital Health and Care Strategy. 2021.
- Supportive and Palliative Care Indicators Tool (SPICT). REDMAP framework. 2023.

Tools and Resources:

- NHS Inform. Future Care Planning. 2024.
- Resuscitation Council UK. ReSPECT.
- NHS Education for Scotland (NES). Anticipatory Care Planning (REDMAP). 2022.

Primary Driver
Person-centred care

Secondary Driver	Change ideas
Treatment escalation planning (TEP)	Locally agreed criteria for completion of person centred TEP
	Locally agreed processes for future care plans to inform, and be informed by, TEP discussions
	Processes support timely person centred planning by person's own care team to guide decision making out of hours

Evidence and Guidelines:

- Scottish Intercollegiate Guidelines Network. SIGN 167 Care of deteriorating patients. A national clinical guideline. 2023.
- Taylor DR, Lightbody CJ, Venn R, Ireland A. Responding to the deteriorating patient: The rationale for treatment escalation plans. J R Coll Physicians Edinb. 2022;52(2):172-9.
- Warner BE, Lound A, Grailey K, Vindrola-Padros C, Wells M, Brett SJ. Perspectives of healthcare professionals and older patients on shared decision-making for treatment escalation planning in the acute hospital setting: a systematic review and qualitative thematic synthesis. EClinicalMedicine. 2023;62:102144

Tools and Resources:

- NHS Education for Scotland (NES). Treatment Escalation Planning (TEP) REDMAP Masterclass Toolkit. 2022.

Primary Diver

Recognition of acute deterioration

Secondary Driver	Change ideas			
Use of NEWS2 and clinical judgement	Timely and reliable use of NEWS2 to identify physical deterioration	Use of clinical judgement to identify physical deterioration	NEWS2 parameters adjusted to reflect individual physiological baseline	Assessment recognises variation in presentation, e.g. considerations of ethnicity in pulse oximetry, deterioration in optimal posture
Action on patient, family or carer concern	Locally agreed process for patients, families and carers to raise concerns about acute deterioration	Patient, family and carer view of illness and concerns consistently sought e.g. asking 'how well are you feeling compared to the last time we asked you?'	Locally agreed process for staff to document and escalate concerns raised by patients, families and carers	Process to reliably provide feedback to the person who raised concern
Identification of people at higher risk of deterioration	Proactive identification of presentations at higher risk of deterioration e.g. sepsis	Process to identify people with significant co-morbidities, frailty or complex care needs at higher risk of deterioration	Identify people on a deteriorating health trajectory with an advanced condition who may benefit from earlier care planning discussions e.g. SPICT tool	

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Recognition of acute deterioration

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Use of NEWS2 and clinical judgement	Timely and reliable use of NEWS2 to identify physical deterioration	Use of clinical judgement to identify physical deterioration	NEWS2 parameters adjusted to reflect individual physiological baseline	Assessment recognises variation in presentation, e.g. considerations of ethnicity in pulse oximetry, deterioration in optimal posture

Evidence and Guidelines:

- Bucknall TK, Considine J, Harvey G, et al. Prioritising Responses Of Nurses To deteriorating patient Observations (PRONTO): a pragmatic cluster randomised controlled trial evaluating the effectiveness of a facilitation intervention on recognition and response to clinical deterioration. BMJ Qual Saf. 2022.
- National Institute for Health and Care Excellence. National Early Warning Score systems that alert to deteriorating adult patients in hospital.
- Scottish Intercollegiate Guidelines Network. SIGN 167 Care of deteriorating patients. A national clinical guideline.
- Scottish Intercollegiate Guidelines Network. SIGN 157 Risk reduction and management of delirium. A national clinical guideline.
- UK Government. Equity in medical devices: independent review. 2024.
- Velhuis LI, Ridderikhof ML, Bergsma L, et al. Performance of early warning and risk stratification scores versus clinical judgement in the acute setting: a systematic review. EMJ. 2022; 39:918-923

Tools and Resources:

- NHS Education for Scotland (NES). National early warning score (NEWS) in NHS Scotland. 2021.

Primary Diver

Recognition of acute deterioration

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Action on patient, family or carer concern	Locally agreed process for patients, families and carers to raise concerns about acute deterioration	Patient, family and carer view of illness and concerns consistently sought e.g. asking 'how well are you feeling compared to the last time we asked you?'	Locally agreed process for staff to document and escalate concerns raised by patients, families and carers	Process to reliably provide feedback to the person who raised concern

Evidence and Guidelines:

- Bucknall T, Quinney R, Booth L, McKinney A, Subbe CP, Odell M. When patients (and families) raise the alarm: Patient and family activated rapid response as a safety strategy for hospitals. Future Healthc J. 2021;8(3):e609-e612.
- McCoy L, Lewis JH, Simon H, et al. Learning to Speak Up for Patient Safety: Interprofessional Scenarios for Training Future Healthcare Professionals. J Med Educ Curric Dev. 2020;7:2382120520935469.
- McKinney A, Fitzsimons D, Blackwood B, McGaughey J. Patient and family involvement in escalating concerns about clinical deterioration in acute adult wards: A qualitative systematic review. Nurs Crit Care. 2021;26(5):352-362.

Tools and Resources:

- NHS Inform. Communication and involving you. 2023.
- Patient Safety Commissioner. Martha's Rule working group holds first meeting. 2024.

Primary Diver

Recognition of acute deterioration

Secondary Driver	Change ideas

Identification of people at higher risk of deterioration	Proactive identification of presentations at higher risk of deterioration e.g. sepsis	Process to identify people with significant co-morbidities, frailty or complex care needs at higher risk of deterioration	Identify people on a deteriorating health trajectory with an advanced condition who may benefit from earlier care planning discussions e.g. SPICT tool

Evidence and Guidelines:

- Goodacre S, Fuller G, Conroy S, Hendrikse C. Diagnosis and management of sepsis in the older adult. BMJ. 2023;382:e075585.
- National Institute for Health and Care Excellence. National Early Warning Score systems that alert to deteriorating adult patients in hospital. Medtech innovation briefing.
- Scottish Intercollegiate Guidelines Network. SIGN 167 Care of deteriorating patients. A national clinical guideline.
- Wood C, Chaboyer W, Carr P. How do nurses use early warning scoring systems to detect and act on patient deterioration to ensure patient safety? A scoping review. Int J Nurs Stud. 2019;94:166-178.

Tools and Resources:

- Healthcare Improvement Scotland SPSP Acute Adult Programme Sepsis Change Package. 2023

Primary Driver

Standardised, structured response and review

Secondary drivers	Change ideas			
A structured response to deterioration	Locally agreed standardised approach to structured response to deterioration	Structured response aligns with patient wishes included in TEP and Future Care Plan	Locally agreed process for contacting next of kin or identified key contact at point of deterioration	Effective use of system-wide escalation capacity e.g. outreach team, electronic NEWS2 and decision support
Senior clinical decision maker review	Local escalation processes enable early involvement of a senior clinical decision maker	Locally agreed process for critical care review	Timely first Consultant review within 14hrs of hospital admission and daily thereafter	Local escalation processes include who to contact during specific time periods e.g. day shift, evening, night shift
Regular review and reassessment	Reassessment criteria documented as part of the management plan, including who to contact	Review working diagnosis and treatment goals at every reassessment	Patients, families, and carers are given advice to support identification of further deterioration using agreed communication method	

Primary Driver

Standardised, structured response and review

Secondary Driver	Change ideas
A structured response to deterioration	Locally agreed standardised approach to structured response to deterioration
	Structured response aligns with patient wishes included in TEP and Future Care Plan
	Locally agreed process for contacting next of kin or identified key contact at point of deterioration
	Effective use of system-wide escalation capacity e.g. outreach team, electronic NEWS2 and decision support

Evidence and Guidelines:

- Burke JR, Downey C, Almoudaris AM. Failure to Rescue Deteriorating Patients: A Systematic Review of Root Causes and Improvement Strategies. J Patient Safety. 2022. 18(1): e140-e155
- Scottish Intercollegiate Guidelines Network. SIGN 167 Care of deteriorating patients. A national clinical guideline. 2023.
- Sujan M, Bilbro N, Ross A, et al. Failure to rescue following emergency surgery: a FRAM analysis of the management of the deteriorating patient. Applied Ergonomics. 98 (Jan 22) 103608

Tools and Resources:

- Healthcare Improvement Scotland. Right Decision Service. Response to deterioration. 2023.
- Healthcare Improvement Scotland. SPSP Acute Adult. Principles of Structured response to Deterioration. 2022.
- Healthcare Improvement Scotland. SPSP Acute Adult. Structured Response to Deterioration: Mapping Tool. 2023.
- NHS Education for Scotland (NES). Recognising and responding when a person is deteriorating. 2022.

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Evidence and Guidelines:

- Hong JQY, Chua WL, Smith D, Huang CM, Goh QLP, Liaw SY. Collaborative practice among general ward staff on escalating care in clinical deterioration: A systematic review. J Clin Nurs. 2023;32(17-18):6165-6178.
- Hotta S, Ashida K, Tanaka M. Night-time detection and response in relation to deteriorating inpatients: A scoping review. Nurs Crit Care. 2023;1-13.
- National Institute for Health and Care Excellence. Emergency and acute medical care in over 16s. Quality standard [QS174]. 2018.
- Scottish Intercollegiate Guidelines Network. SIGN 167 Care of deteriorating patients. A national clinical guideline. 2023.

Tools and Resources:

- Healthcare Improvement Scotland. Right Decision Service. Response to deterioration. 2023.
- Healthcare Improvement Scotland. SPSP Acute Adult. Principles of Structured response to Deterioration. 2022.
- Healthcare Improvement Scotland. SPSP Acute Adult. Structured Response to Deterioration: Mapping Tool. 2023.

Primary Driver

Standardised, structured response and review

Secondary Driver	Change ideas
Regular review and reassessment	Reassessment criteria documented as part of the management plan, including who to contact
	Review working diagnosis and treatment goals at every reassessment
	Patients, families, and carers are given advice to support identification of further deterioration using agreed communication method

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- Bucknall T, Quinney R, Booth L, McKinney A, Subbe CP, Odell M. When patients (and families) raise the alarm: Patient and family activated rapid response as a safety strategy for hospitals. Future Healthc J. 2021;8(3):e609-e612.
- Scottish Intercollegiate Guidelines Network. SIGN 167 Care of deteriorating patients. A national clinical guideline.

Tools and Resources:

- Healthcare Improvement Scotland. SPSP Acute Adult. Principles of Structured Response to Deterioration. 2022.
- Healthcare Improvement Scotland. SPSP Acute Adult. Structured Response to Deterioration: Mapping Tool. 2023.
- NHS Inform. Communication and involving you.

Primary Driver

Safe communication within and between teams

Secondary drivers	Change ideas				
Interdisciplinary teamwork and collaboration	Clarity of team roles and responsibilities in acute deterioration	Handovers highlight high acuity patients at risk of deterioration	Multidisciplinary structured ward rounds	Local process to identify deteriorating patients within a clinical area and hospital wide e.g. at safety huddles, and team briefs	Local induction processes for all staff include introduction to MDT and local handover tools
Safe transitions in care	Structured handovers within and between teams e.g. use of SBAR	Including future care plan and/or TEP in all communication between teams	Local process for safe transfer of care of deteriorating patients	Patient, family and carers are included handovers e.g. bedside handovers in partnership with patients	Patient placement decisions informed by clinical condition and level of care
Psychological safety to support escalation of concerns	Processes to support a culture which supports staff and students to raise concerns	Process for managers at all levels to effectively recognise and respond to patient safety concerns	Promotion of Speak Up advocates and ambassadors to encourage staff to raise concerns	Structured process for multidisciplinary hot and cold debriefs	

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Evidence and Guidelines:

- Care Quality Commission. PEOPLE FIRST: Escalation. 2023.
- Hong JQY, Chua WL, Smith D, Huang CM, Goh QLP, Liaw SY. Collaborative practice among general ward staff on escalating care in clinical deterioration: A systematic review. J Clin Nurs. 2023;32(17-18):6165-6178.
- McLaney E, Morassaei S, Hughes L, Davies R, Campbell M, Di Prospero L. A framework for interprofessional team collaboration in a hospital setting: Advancing team competencies and behaviours. Healthcare Management Forum. 2022;35(2):112-117.
- Merriman C, Freeth D. Conducting a good ward round: How do leaders do it?. J Eval Clin Pract. 2022;28(3):411-420. doi:10.1111/jep.13670

Tools and Resources:

- Institute for Healthcare Improvement. Patient Safety Essentials Toolkit. 2019.

Primary Driver

Safe communication within and between teams

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Safe transitions in care	Structured handovers within and between teams e.g. use of SBAR	Including future care plan and/or TEP in all communication between teams	Local process for safe transfer of care of deteriorating patients	Patient, family and carers are included handovers e.g. bedside handovers in partnership with patients	Patient placement decisions informed by clinical condition and level of care

Evidence and Guidelines:

- Cho S, Lee JL, Kim KS, Kim EM. Systematic Review of Quality Improvement Projects Related to Intershift Nursing Handover. J Nurs Care Qual. 2022;37(1):E8-E14.
- Clari M, Conti A, Chiarini D, Martin B, Dimonte V, Campagna S. Barriers to and Facilitators of Bedside Nursing Handover: A Systematic Review and Meta-synthesis. J Nurs Care Qual. 2021;36(4):E51-E58.

Tools and Resources:

- Healthcare Improvement Scotland. SPSP Acute Adult. Principles of Structured response to Deterioration. 2022.
- Healthcare Improvement Scotland. SPSP Acute Adult. Structured Response to Deterioration: Mapping Tool. 2023.
- NHS Education Scotland (NES). SBAR. 2017.

Primary Driver

Safe communication within and between teams

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Psychological safety to support escalation of concerns	Processes to support a culture which supports staff and students to raise concerns	Process for managers at all levels to effectively recognise and respond to patient safety concerns	Promotion of Speak Up advocates and ambassadors to encourage staff to raise concerns	Structured process for multidisciplinary hot and cold debriefs

Evidence and Guidelines:

- Hong JQY, Chua WL, Smith D, Huang CM, Goh QLP, Liaw SY. Collaborative practice among general ward staff on escalating care in clinical deterioration: A systematic review. J Clin Nurs. 2023;32(17-18):6165-6178.
- NHS Providers. Psychological Safety and Why It Matters.
- O'Donovan R, Mcauliffe E. A systematic review of factors that enable psychological safety in healthcare teams. International Journal for Quality in Health Care. 2020. 32(4):240-250

Tools and Resources:

- Healthcare Improvement Scotland. Maternity and Children Quality Improvement Collaborative (MCQIC), Safety Culture Webinar Series. Theme: Psychological Safety. 2022.
- TURAS Learn. National Whistleblowing Standards training. 2021.
- TURAS Learn. Speaking up: national whistleblowing guidance for nursing and midwifery students in Scotland. 2021.

Primary Driver:
Leadership to support a culture of high quality care and patient safety

Secondary drivers	Change ideas				
Visible leadership at all levels	Conduct and share learning from leadership walkrounds	Access to clinical and improvement leadership time e.g. deteriorating patient lead	Opportunity for senior leaders to review deteriorating patient related data and trends	Deteriorating patient improvement priorities align with organisational priorities	Improvement team includes clinical and QI expertise e.g. resus and QI colleagues
Safe staffing* and resources to enable delivery of safe care	Identify and mitigate staffing needs using real time staffing tools, including acuity assessment	Process to escalate staffing shortfalls	Education and induction includes local processes for structured response to deterioration	Identify and mitigate time periods where escalation response is less reliable	
System for learning* to support continuous improvement	Develop reliable data collection process e.g. through process mapping	Share, and act on reliable data and learning between teams, hospitals, and boards	Identify and share learning through existing processes e.g. MDT morbidity and mortality meetings	Forums for staff, patients, and carers to identify areas for improvement	Education and simulation to support improvement in communication and technical skills
Staff wellbeing	Use of effective health and wellbeing conversations to identify and mitigate risks to wellbeing	Prioritise civility through communication and teamwork, e.g. use of TeamSTEPPS	Support job satisfaction through evidence based interventions e.g., Professional Identity Development Programme	Access to senior support and discussion for all staff, e.g. through clinical supervision	

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Evidence and Guidelines:

- Churruca K, Ellis LA, Pomare C, et al. Dimensions of safety culture: a systematic review of quantitative, qualitative and mixed methods for assessing safety culture in hospitals. BMJ Open. 2021;11(7):e043982

Tools and Resources:

- Institute for Healthcare Improvement. Leading a Culture of Safety: A Blueprint for Success. 2017
- NHS Education for Scotland. Safety Culture Discussion Cards. 2018.
- The King's Fund. The practice of collaborative leadership: Across health and care services. 2023.

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Evidence and Guidelines:

- Hotta S, Ashida K, Tanaka M. Night-time detection and response in relation to deteriorating inpatients: A scoping review. Nurs Crit Care. 2023; 29(1):178-190
- Liu Q, Zheng X, Xu L, Chen Q, Zhou F, Peng L. The effectiveness of education strategies for nurses to recognise and manage clinical deterioration: A systematic review. Nurse Educ Today. 2023;126:105838.
- Scottish Government. Health and Care (Staffing) (Scotland) Act 2019: overview. 2024.

Tools and Resources:

- Healthcare Improvement Scotland. Workforce capacity and capability. 2021.
- Healthcare Improvement Scotland. Inclusion and involvement. 2021.
- Healthcare Improvement Scotland. Staffing level (workload) tools and methodology.
- NHS Education for Scotland. Health and Care Staffing in Scotland. 2022.

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Leadership to support a culture of high quality care and patient safety

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Evidence and Guidelines:

- Healthcare Improvement Scotland. Learning from adverse events through reporting and review. A national framework for Scotland: December 2019.
- Institute for Healthcare Improvement. Leading a Culture of Safety: A Blueprint for Success. 2017.
- Theilan U, Fraser L, Jones P, et al. Regular in-situ simulation training of paediatric Medical Emergency Team leads to sustained improvements in hospital response to deteriorating patients, improved outcomes in intensive care and financial savings. Resuscitation. 2017;115:61-67.

Tools and Resources:

- Healthcare Improvement Scotland. SPSP MCQIC Safety Culture Webinar Series, Systems for Learning. Part 1. Part 2. 2022.
- Healthcare Improvement Scotland. Quality Management System. 2022.
- Healthcare Improvement Scotland. The Essentials of Safe Care: System for Learning. 2021.

Primary Driver:
Leadership to support a culture of high quality care and patient safety

Secondary Driver	Change ideas			
Staff wellbeing	Use of effective health and wellbeing conversations to identify and mitigate risks to wellbeing	Prioritise civility through communication and teamwork, e.g. use of TeamSTEPPS	Support job satisfaction through evidence based interventions e.g., Professional Identity Development Programme	Access to senior support and discussion for all staff, e.g. through clinical supervision

Evidence and Guidelines:

- Cohen C, Pignata S, Bezak E, Tie M, Childs J. Workplace interventions to improve well-being and reduce burnout for nurses, physicians and allied healthcare professionals: a systematic review. BMJ Open. 2023;13(6):e071203.
- Tulleners T, Campbell C, Taylor M. The experience of nurses participating in peer group supervision: A qualitative systematic review. Nurse Educ Pract. 2023;69:103606.

Tools and Resources:

- Agency for Healthcare Research and Quality. Team STEPPS. Team Strategies & Tools to Enhance Performance & Patient Safety.
- Healthcare Improvement Scotland. The Essentials of Safe Care: Staff Wellbeing.
- National Wellbeing Hub.
- NHS Education for Scotland (NES). Staff Wellbeing Resources.
- NHS Employers. Health and wellbeing conversations.

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