NHS Ayrshire & Arran

Meeting:	**NHS Ayrshire and Arran Board**
Meeting date:	**Monday 6 October 2025**
Title:	**Quality and Safety – Acute Services**
Responsible Director:	**Vicki Campbell, Director of Acute Services**
Report Author:	**Stephanie Frearson, Acute QI Lead** **Nina McGinley, Board Excellence in Care Clinical Lead & Lead for Practice Development** **Gillian Biggans, Resuscitation Service Lead** **Linda Robertson, QI Lead Nurse Professional Development FFN** **Michelle Sayers-Jones, Chief Nurse**

1. Purpose

This is presented to the Board for:

- Awareness

This paper relates to:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2. Report summary

2.1 Situation

This paper is for information to the NHS Board following detailed discussion at Healthcare Governance Committee. The paper provides an overview of quality and safety activity within NHS Ayrshire & Arran Acute services.

2.2 Background

NHS Ayrshire & Arran (NHSAA) participated in the Scottish Patient Safety Programme (SPSP) Acute Adult Collaborative, a national initiative aimed at improving the safety and reliability of health and social care and reducing harm. This programme concluded in June 2024. Building on this work, NHSAA has developed local Quality Improvement (QI) programmes focused on key priorities including falls prevention, reduction of acquired pressure ulcers (PUs), and the recognition and response to deteriorating patients.

NHSAA participates in Excellence in Care (EiC) a national assurance programme which aims to ensure people have confidence they will receive a consistent standard of high-quality of care no matter where they receive treatment in NHS Scotland, providing consistent, robust processes and systems for measuring, assuring, and reporting on the quality of care and practice.

2.3 Assessment

Within NHSAA adverse events such as Falls, Falls with Harm, Pressure Ulcers, Food, Fluid and Nutrition and Cardiac Arrest are reported via Datix with monthly reporting and scrutiny of quality-of-care data reported via the Acute Services Quality and Safety meeting for assurance.

SPSP: As part of the SPSP Acute Adult Programme, all health boards are invited to report Falls, Falls with Harm and Cardiac Arrest data to Healthcare Improvement Scotland (HIS). NHSAA have achieved a sustained 13% reduction in all falls across both acute sites between February 2023 and June 2025. Pressure ulcers have increased by 22% across both acute sites. No improvement is noted in cardiac arrest rates.

EiC: As part of the EiC Programme; Falls, Pressure Ulcers, Food Fluid and Nutritional Assessment, National Early Warning Score, Workforce and Quality Management Practice Learning Environment (QMPLE) data is submitted to Public Health Scotland. NHSAA also report to Scottish Government bi-annually providing an organisational position on implementation and assurance of Excellence in Care.

Complaints: This data is presented for the first time as part of this paper and describes the previous six-month period. For stage 1 complaints the target of 85% closed within 5-10 working days and for stage 2, of 75% closed within 20 working days is not consistently being achieved. Targeted improvement actions are underway.

Significant Adverse Events: 110 Local Management Team Reviews (LMTR's) and 266 action plans are overdue. 39 Significant Adverse Event Review (SAER) reports and 40 action plans are overdue. Work is underway to address the large number of overdue action plans particularly in relation to pressure ulcers and falls.

Full details of progress of QI work, assurance programmes, complaints and adverse events within Acute Services are detailed in Appendix 1.

2.3.1 Quality/patient care

SPSP provides an opportunity for NHSAA to participate in a national improvement programme aimed at reducing harm and enhancing the experience and outcomes for people in acute care. This is complimented by the EiC assurance programme. SPSP has been undergoing a re-design with a new programme offer due to come to Scottish health boards in coming months.

2.3.2 Workforce

Sustainable improvement in patient care can only be achieved when staff are fully engaged and empowered. Active participation in both SPSP, EiC, management of complaints and learning from adverse events is essential to enhancing patient experience, improving clinical outcomes, and delivering high-quality, person-centred care.

2.3.3 Financial

Reduced engagement and underperformance in relation to SPSP and EiC measures may have financial implications. For example, increased incidence of falls can contribute to extended hospital stays, increased resource utilisation, and higher associated costs.

2.3.4 Risk assessment/management

Failure to engage with national improvement programmes, complaints and adverse events management may increase the risk of patient harm, generate complaints, lead to potential litigation, and result in adverse publicity for the organisation.

2.3.5 Equality and diversity, including health inequalities

An impact assessment has not been completed.

2.3.6 Other impacts

- Best value
  - Vision and Leadership
  - Governance and accountability
- Compliance with Corporate, Nursing midwifery and allied health professionals (NMAHP) and Quality Strategy Objectives

2.3.7 Communication, involvement, engagement and consultation

All programmes of work require sustained communication, engagement, and collaboration with key stakeholders to ensure successful implementation and impact. To date, stakeholder involvement has included:

- Regular updates to relevant governance and improvement groups
- Participation in local and national SPSP/EiC learning
- Provision of access to local and site-level data to inform decision-making and improvement activity.

2.3.8 Route to the meeting

This paper was discussed at Healthcare Governance Committee on the 5 September 2025.

2.4. Recommendation

For awareness. The Board is asked to note the quality and safety activity within NHS Ayrshire & Arran Acute services.

3. List of appendices

The following appendices are included with this report:

- Appendix 1 – Acute Services Quality and Safety Update

APPENDIX 1

Acute Services Quality and Safety Update

1. Introduction

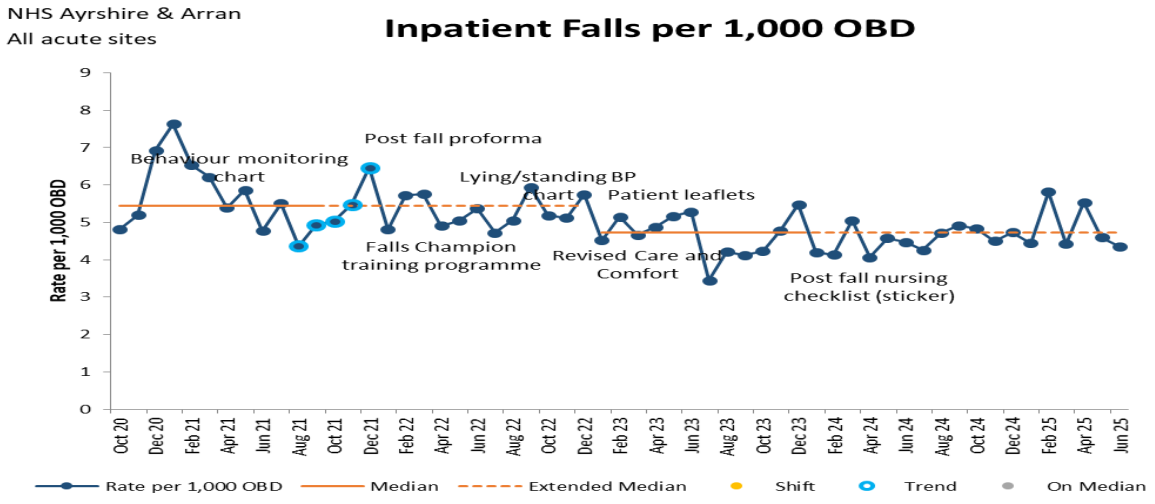
This paper outlines quality of care and safety progress in alignment with both national and local initiatives and describes the current progress and plans going forward in relation to patient safety measures including:

- Falls
- Falls with harm
- Pressure Ulcers
- Cardiac Arrest
- National Early Warning Score
- Food Fluid and Nutrition
- Complaints/feedback
- Significant Adverse Event Reviews

2. Falls / Falls with Harm

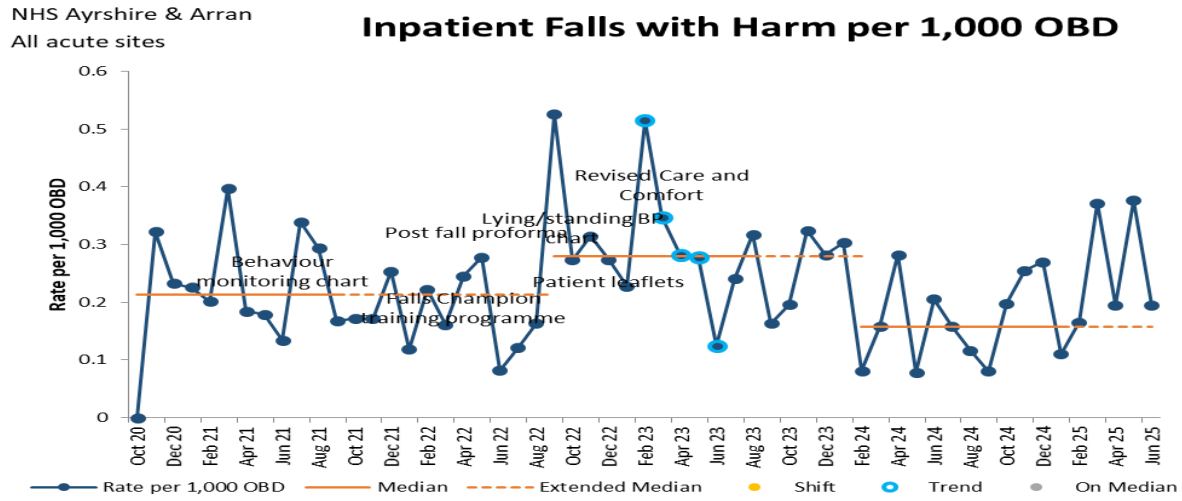
NHS Ayrshire and Arran (NHSAA) previously participated in the Scottish Patient Safety Programme (SPSP) Acute Adult Collaborative (Sept 2021 – Mar 2024), with a focus on reducing inpatient falls and falls with harm (FWH). Over the course of the collaborative NHSAA falls data demonstrated a reduction of 13% (Chart 1) across both acute sites which has been sustained.

Chart 1: All Falls rate for All Acute Sites



The incidence of falls with harm (FWH) has a decreased since February 2024 with the median rate currently 0.15 per 1000 OBD's (Chart 2). The last 5 months data points are above the median indicating a recent increase in falls with harm.

Chart 2: Falls with harm rate All Acute Sites



2.1 Falls Co-ordinators

The Falls Coordinator's (FC) continue to support teams to progress falls improvement and prevention work. Monthly falls count data is shared with clinical and management teams and hotspot SBAR's are compiled for wards with 7 or more falls in one month to highlight themes. Additionally, the FC's have supported and contributed to the progression of the following:

- Review of Essential care after an inpatient fall guidance.
- Review of Management of falls in hospital, higher level supervision and safe use of bedrails guidance.
- Development of bedrail risk assessment/falls risk assessment – both currently undergoing testing.
- Falls champion development sessions, planned for later in 2025.

2.2 Acute Falls Group/ Targeted Falls Improvement Work

An Acute Falls Group has been established to provide oversight and drive targeted improvement. Four acute wards at both acute sites are participating in an 18-month improvement programme focusing on four key areas commonly linked to inpatient falls:

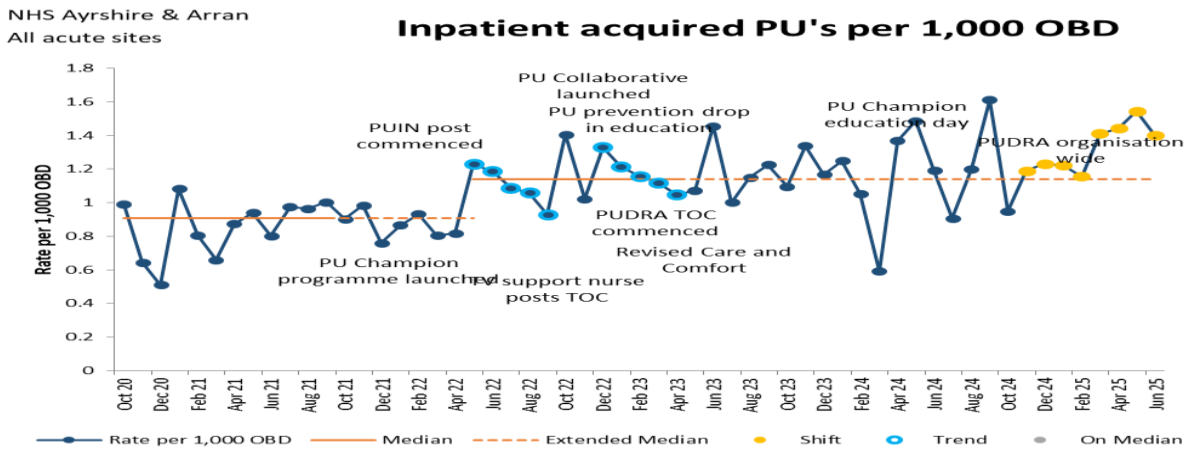
1. Delirium
2. Continence
3. Falls Interventions
4. Enhanced Supervision

Each ward has received a workbook with evidence-based change ideas. To support implementation, the FC's, QI team, and subject matter experts have delivered four workshops and two continence-specific sessions. Additional workshops on delirium, nutrition, and falls prevention are planned.

3. Pressure Ulcers

An NHSAA PU Breakthrough Series Collaborative ran from December 2022 to August 2024, with the aim of driving improvements in PU prevention across the acute sites. Initial improvements were demonstrated at UHA site, these have not been sustained. An increase in acquired PU rate across both acute sites of 22% is demonstrated (Chart 3). Recent data demonstrates a further increase in PU's with eight points above the median from December 2024.

Chart 3: Rate of acquired pressure ulcers - All Acute Sites



Following conclusion of the Collaborative a multidisciplinary workshop was held in August 2024, bringing together colleagues to focus on sharing learning, identifying key areas for improvement, and planning next steps. Key improvement priorities identified included:

- Assessing current resources, identifying gaps, and implementing systems to streamline access to essential PU equipment in acute care settings
- Co-designing a targeted PU improvement plan
- PU education and training for staff

3.1 Pressure Ulcer Improvement Nurse (PUIN)

The PUIN continues to support teams to progress improvement and prevention initiatives. Monthly data is shared with teams, and a hotspot SBAR is produced for any ward reporting five or more PUs in a month to highlight emerging themes. To date, 94 PU Champions have been trained across the acute sites and PU specific training continues.

In collaboration with the National Association of Tissue Viability Nurse Specialists (Scotland), the PUIN has also contributed to the review of the current NHS Education Scotland PU LearnPro module.

3.2 Acute Pressure Ulcer Group/ Targeted Pressure Ulcer Improvement Work

An Acute PU Group has been established to provide oversight and drive targeted improvement. Eight wards across the acute sites are participating in an 18-month improvement programme. The programme focuses on four key areas:

1. Improved Communication and Education
2. Enhanced Clinical Practice and Documentation
3. Improved Access and Processes for PU equipment
4. Multidisciplinary Team (MDT) Improvement Opportunities

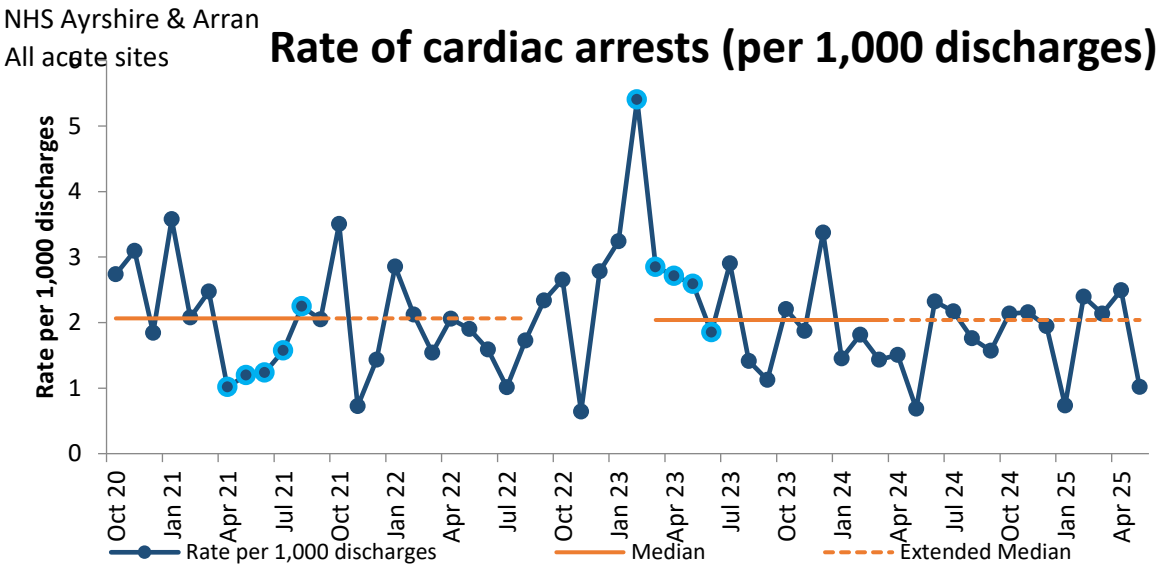
Each ward has received a workbook containing evidence-based change ideas. To support implementation, the PUIN, QI team, and subject matter experts have delivered introductory workshops, along with two sessions focused on continence care. Additional workshops are scheduled throughout the programme timeline.

4. Deteriorating Patient

4.1 Cardiac Arrest

Cardiac arrest rates at both acute sites continue to show normal variation with a median rate of 2.0 as demonstrated in chart 4. NHSAA rate is above the national median of 1.2.

Chart 4: NHSAA Acute Sites Cardiac Arrest Rate



4.2 National Cardiac Arrest Audit (NCCA) - (1st April 2024 -31st March 2025)

National Cardiac Arrest Audit (NCAA) data for UHA demonstrates a 22.2% survival to discharge rate which is an improvement from the last annual report, where survival to discharge was 17.6%.

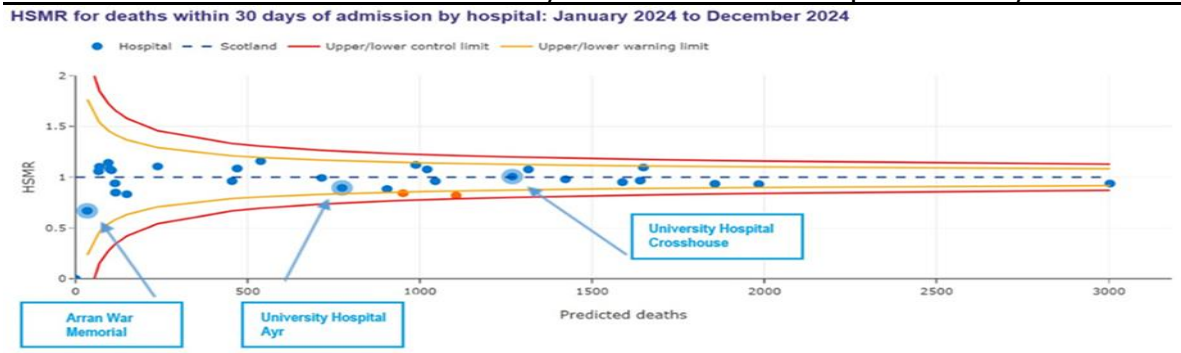
UHC data demonstrates a lower survival to discharge rate of 12.8% however, this is an improvement from last year's survival to discharge of 6.5%. Whilst there has been improvement on both sites, both sites are below the national average for survival to discharge which is 25.8%.

4.3 Hospital Standardised Mortality Ratio

Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect and incorporates patients who have died within 30 days of admission. HSMR data is published quarterly with the latest 12-month reporting period January 2024 to December 2024.

UHA is below the predicted HSMR ratio of 1.00 at 0.90, which is lower than the previous reporting period which was 0.93. UHC is above the predicted ratio at 1.01, which is higher than the previous reporting period which was 0.95. HSMR for deaths within 30 days of admission to hospital demonstrate that both acute sites are within the standardised mortality ratio control limits as displayed in chart 5.

Chart 5: HSMR for Deaths within 30 days of admission to hospital January-December 2024



4.4 Cardiac Arrest Reviews

Resuscitation Services have reviewed 100% of true cardiac arrests at both acute sites between January and July 2025. Table 1 displays cardiac arrest review key findings:

Table 1: Key findings from Cardiac Arrest Reviews January –July 2025

Finding	UHC	UHA
Resuscitation was appropriate	47%	36%
DNACPR would have been appropriate	35%	46%
Failure to recognise deterioration	12%	9%
Cardiac arrest was preventable with a different intervention	6%	9%

Key findings from cardiac arrest reviews are consistent with the previous reporting period. Do not attempt cardiopulmonary resuscitation (DNACPR) would have been appropriate continues to be a key area for improvement. To support improvements a Treatment Escalation Planning Collaborative is being developed within the acute sites.

Treatment Escalation Plan (TEP) is a tool which records and communicates the personalised and realistic goals of treatment. It should reflect the values and preferences that are important to the person receiving care if their condition should deteriorate. An initial workshop with key stakeholders took place on the 9th of June 2025. A work plan has been developed and is inclusive of a plan to revise the current acute and community TEPs, collect further baseline data and explore the use of the frailty score in determining who should have a TEP put in place. This work is in conjunction with the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) collaborative to promote alignment.

Learning identified from cardiac arrest reviews continues to be shared with areas where the cardiac arrest occurred and wider with key groups.

A process for cardiac arrest review teams to escalate cases for further review to the Adverse Event Review Group (AERG) is established with 20% of all cardiac arrests at UHA and 19% at UHC escalated to AERG for review since January 2025.

5. Nutrition and Hydration

Food, Fluid and Nutrition (FFN) standards data is collected monthly from all inpatient wards across both acute sites. The Malnutrition Universal Screening Tool (MUST) is used nationally as a method to screen patients who are at risk of malnutrition,

malnourished or obese. Chart 6 demonstrates median rate of compliance for MUST Screening at UHA of 93% and 90% at UHC (Chart 7).

Chart 6: UHA - MUST % Compliance

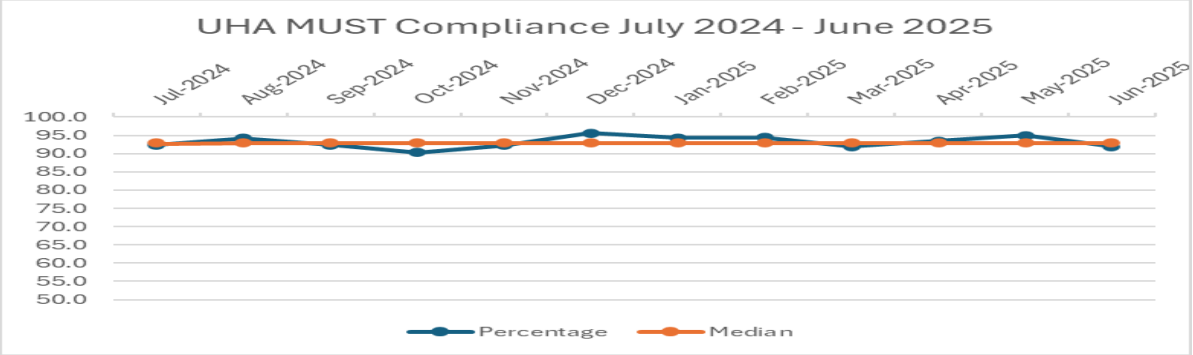
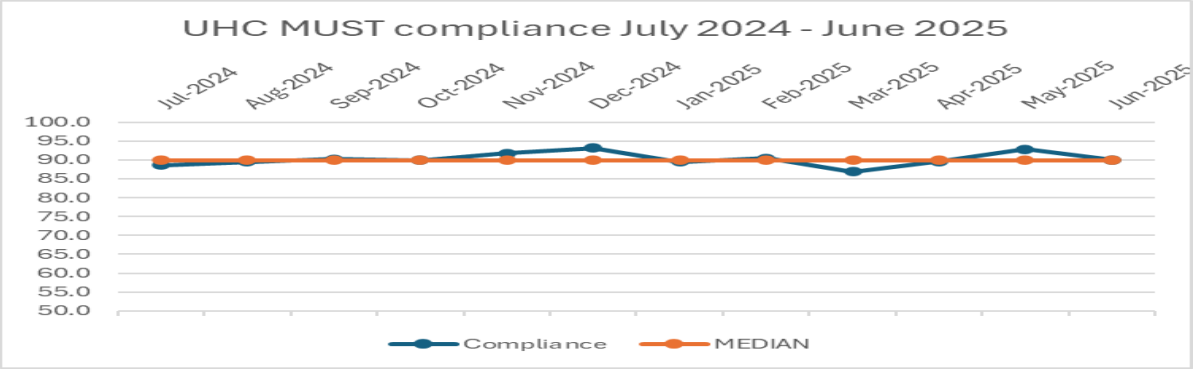


Chart 7: UHC - MUST % Compliance



Data is shared with teams for review and action and presented by FFN Lead at the Acute Quality and Safety Oversight meeting bi-monthly to appraise any necessary actions of improvement and support required.

5.1 Nutrition and Hydration Education

The Nutrition and Hydration champions programme provides a forum for education, sharing good practices and supports upskilling of both Registered and HCSW staff to support and drive forward nutrition and hydration practice. To improve representation from acute areas, communication with leads continues.

Table 2: Number of wards with nominated nutrition and hydration champions per site

Hospital	Total Number of wards	Number of wards/ dept with nominations
UHA	19	4
UHC	23	10

Nutrition, Dysphagia and Hydration modules are currently provided by an external provider. Development of updated Dysphagia modules is being undertaken by Speech and Language Therapy (SLT) Consultant with resources available late summer. Review of nutrition and hydration modules has taken place and future updates in line with output from staff needs analysis will be rolled out autumn 2025.
Table 3 displays the total percentage of staff that have completed the current LearnPro modules within Acute Services.

Table 3: Percentage of staff completed LearnPro modules

Level of Training	Total Percentage of Acute staff
Level 1	74%
Level 2	66%
Level 3	47%

An in-person education programme is under development to complement LearnPro modules and Nutrition Champions education. Inclusion of nutrition and hydration education is also part of the Ensuring Safe Care programme and through student forum.

6. Quality and Safety Oversight Group

The Quality and Safety Oversight Group provides a robust approach to monitoring and scrutiny of quality and assurance process, outcome data and service improvement activity.

A review of the Quality and Safety Measurement Framework has been undertaken and meetings aligned to divisional reporting established. This review has supported expansion of data metrics review and focus on the wider safety agenda. Reporting from divisions now details, successes, challenges and compliance with process measures, which include:

- MAST
- Falls
- Infection Control
- Pressure Ulcers
- Workforce metrics
- Clinical Governance
- Patient Experience and Complaints
- Escalations for support
- FFN
- Medication compliance
- Deteriorating Patient

Data scrutiny has supported identification of areas of excellence and areas for improvement. Review of compliance of quality process measures and audit data has supported an increase in activity and process compliance. The group enables focused oversight of specific areas of improvement work and the development of an Acute Pressure Ulcer Group, Higher Level Supervision Group and Falls Prevention Group. These groups will report into Quality and Safety Oversight Group bi-monthly and provide further assurance and data scrutiny of safe, effective and person-centred care delivery.

Review of governance processes for the meeting have supported a decision to move to bi-monthly meetings for 6 months and then quarterly meetings to align with established reporting into Acute Services Clinical Governance Steering Group reporting.

Due an increase in pressure ulcers an extraordinary pressure ulcer meeting has taken place to review current data, develop and enact new and innovative actions to support reduction and to establish robust governance, oversight and assurance processes.

MAST compliance for acute nursing across most modules has shown improvements with compliance demonstrating the majority sitting above 75%. Focused work will now move to ensuring improvement in IPC education.

PDR activity has been an area of focus with an ambition to achieve more than 50% of staff having a PDR by March 2025, which has been exceeded. Work continues to ensure this is now business as usual.

6.1 Workforce

Nursing vacancy rates for Acute Services is currently 40.72 WTE registered staff and 49.11 WTE unregistered. Work continues to support:

- Establishment requirements
- Specialist clinical area skill mix and establishment reviews
- Mental Health nurse support model within Acute Services
- Eroster/Optima system implementation
- Confirm and support roster meetings – headroom and finance management, releasing workforce back to care.
- Recruitment campaigns

Focus remains on the reduction of additional workforce usage, and the movement from agency workforce to established staff and bank workers. All divisions have shown reduction in the use of additionality except for March where spikes in requests increased. This was consistent with historical headroom management challenges and is being addressed as part of the workforce improvement programme.

Significant work has been undertaken to achieve acute Newly Qualified Nurses (NQN) and Health Care Support Worker (HCSW) open evening/day sessions and recruitment days, interviewing and appointing circa 135 whole time equivalent (WTE) NQN candidates and hosting 150 prospective HCSW. This will allow closure of the vacancy gap, and in addition recruit to both the establishment review paper and reduced working week (RWW).

7. Excellence in Care

Excellence in Care (EiC) is the national Nursing, Midwifery assurance programme. A full review of the national EiC strategy is underway, with publication expected by year end. Quality of Care scrutiny and reporting has a focus on the fundamentals of care and alignment to workforce and measures of quality element of the Common Staffing Method (CSM) Health and Care (Staffing) (Scotland) Act 2019.

Data is reported both locally and nationally via Public Health Scotland Care Assurance and Improvement Resource (CAIR) Dashboard. Acute Services data reporting specific to EiC is inclusive of:

- National Early Warning Score
- Food Fluid and Nutrition
- Multi-Drug-Resistant Organism
- Pressure Ulcer rate
- Falls Rate
- Quality Placement Practice Learning Environment (QMPLE)
- Predictable Absence
- Supplementary Staffing
- Establishment Variance

Assurance of pre-registration Nursing and Midwifery practice learning experience is obtained via the Quality Management Practice Learning Environment (QMPLE) platform. Pre-registration students submit feedback which is then collated and aggregated to

provide NHSAA and Higher Education Institutions assurance that learning needs are met. Both UHA and UHC have demonstrated a shift above the baseline of 90%, highlighting the positive learning experience by pre-registration nursing students. However, it should be noted that % submission of feedback by students is below 50%. Ongoing activity, in collaboration with Practice Education Facilitators, is targeting promotion of completion of QMPLE feedback to support learning.

Chart 8: University Hospital Ayr – QMPLE Score – Run Chart

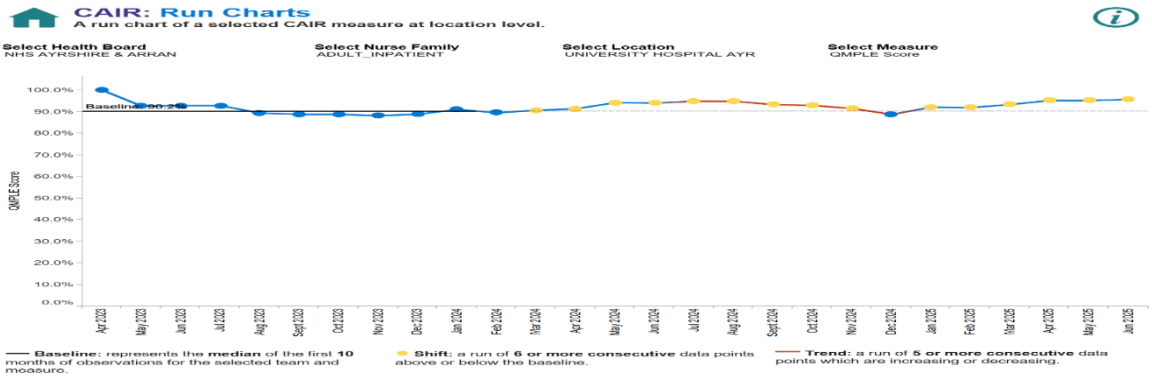
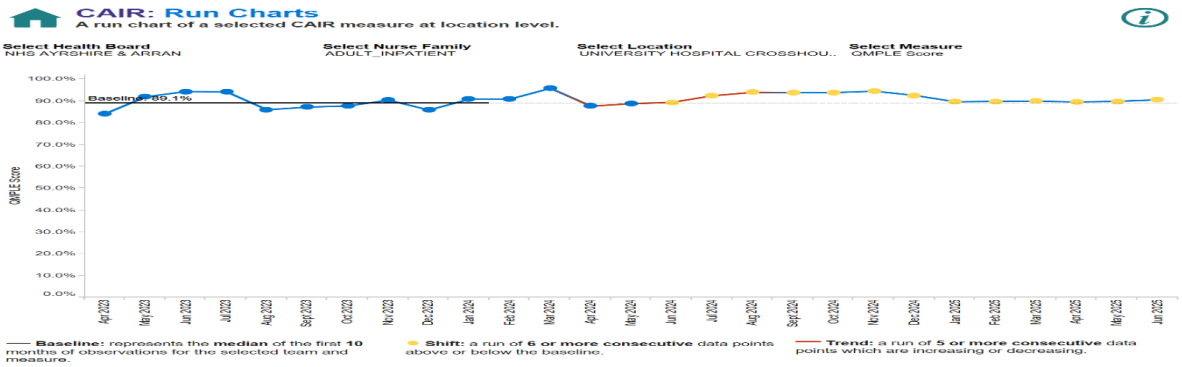


Chart 9: University Hospital Crosshouse – QMPLE Score Run Chart



Key EiC local activities include revision of clinical area assurance boards which will enable Senior Charge Nurses to visibly display quality of care data, areas for improvement and areas of success. Revision of in-patient nursing documentation has been prioritised, with work progressing on quality-of-care risk assessments.

8. Feedback and Complaints

8.1 Complaints Performance and Outcomes

This data is presented for the first time as part of this paper and describes the previous six-month period.

Chart 10 demonstrates the number of concerns and stage 1 complaints received over the last 6 months demonstrating normal variation.

Chart 10: Concerns and Stage 1 Complaints

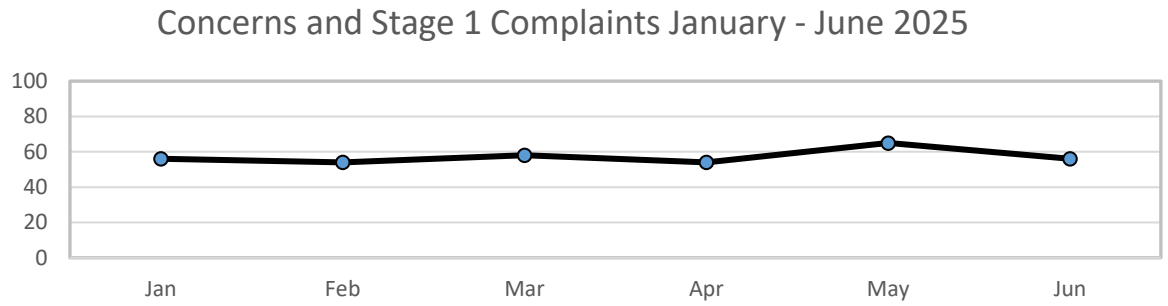


Chart 11 displays the total number of Stage 2 complaints received in the last 6 months. The average number of complaints received is 32 per month.

Chart 11: Stage 2 Complaints

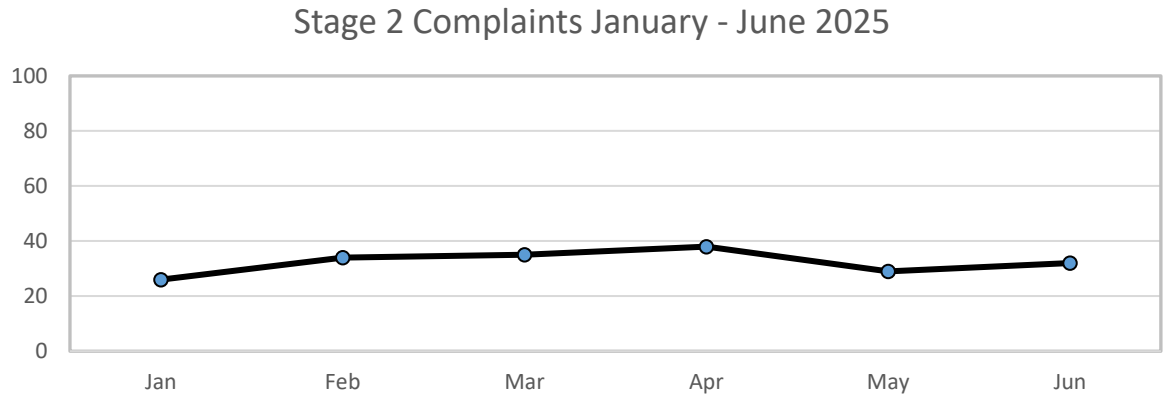
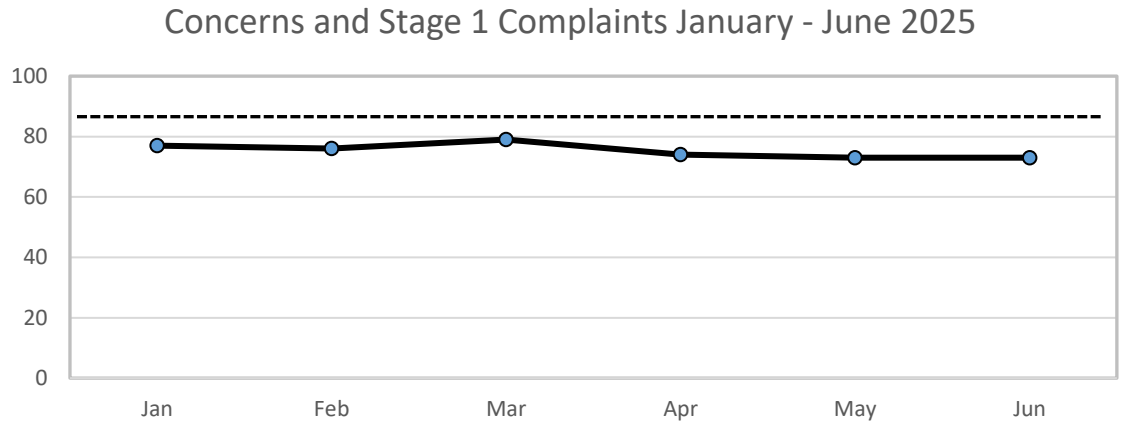


Chart 12 demonstrates compliance for concerns and stage 1 complaints, with Stage 1 complaints closed on time. The target of 85% closed within 5-10 working days is not consistently being achieved.

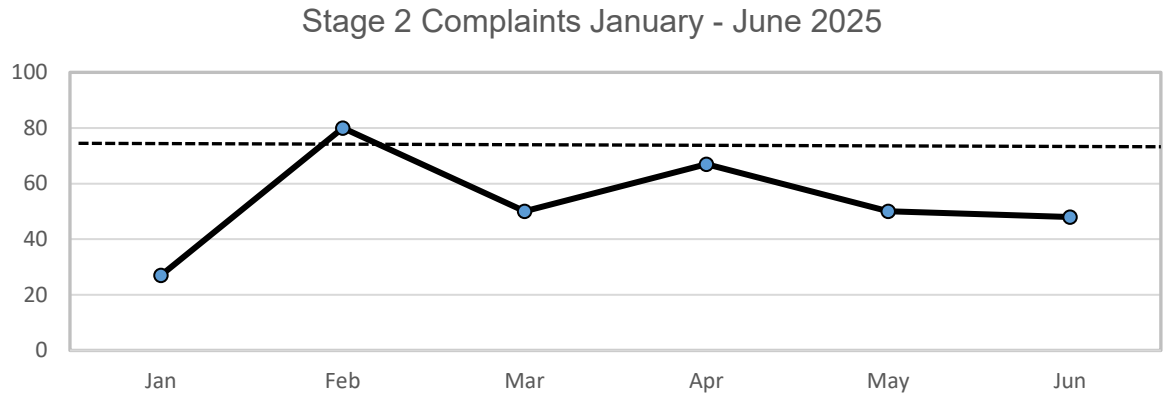
Chart 12: Percentage Concerns and Stage 1 Complaints Closed on Target



Boards are currently set a target of 75% compliance for stage 2 complaints. Please note, a large number of complaints remain open, and compliance has been taken from the closed complaints only. Therefore, compliance is likely to change over time.

Complaint handling performance for Stage 2 complaints is presented in Chart 13

Chart 13: Percentage of Stage 2 Complaints Closed on Target



Work is underway to support improvement in both Stage 1 and Stage 2 performance. The QI Lead for Patient Experience and Complaints Managers are working with Service Managers to agree key targets for improvement and how the Complaints Team can support colleagues to achieve improved complaint handling performance.
Service managers allocated as Investigation Leads are responsible for investigating complaints and passing the findings to the Complaints Team to draft the response. There are currently delays both at the investigation stage and drafting the responses. This aspect of complaint handling is a priority for improvement and the Quality Improvement Lead is meeting with Divisional General Managers to discuss all aspects of complaint handling to determine measures to improve overall compliance.

8.2 Complaint Outcomes

Table 4 displays the complaint outcomes for all complaints resolved within the last 6 months. Most stage 2 complaints remain open.

Table 4: Complaint Outcomes

Service	Not Upheld	Partially Upheld	Fully Upheld	Still Open
Concern / Stage 1	158	48	137	0
Stage 2	15	12	6	161

8.3 SPSO Referrals and Investigations

There was a total of 20 SPSO referrals received in the last 6 months relating to Acute Services and one case has progressed to investigation.

The SPSO is being impacted by a rise in complaint activity and advising there are delays of up to twelve months to review referrals, due to this a rise in future quarters may be seen.

8.4 Complaint Themes

Work has progressed to provide accurate information from complaints. Table 5 displays top three themes and most common subthemes

Table 5: Complaint Themes & Sub themes

Clinical Treatment	Total
Disagreement with treatment / care plan / wrong diagnosis	122
Co-ordination of Clinical treatment	45
Poor medical or nursing treatment	43
Problems with medication	11

Waiting Times	
Unacceptable time to wait for the appointment	130
Test results delayed / mislaid	20
Cancellation of appointment /admission	6
Communication	
Attitude and Behaviour	51
Communication (written)	8
Communication (oral)	31
Competence	7

Themes across Acute Services are reflective of the top five themes across all complaints.

9. Significant Adverse Events

The current status of Significant Adverse Events within Acute Services is shown in table 6 (Local Management Team Reviews) and table 7 (Significant Adverse Event Reviews).

Table 6: Status of Local Management Team Reviews – Acute Services

No of LMTRs Active by Commissioned Date						
Year	**Total No Commissioned**	**Report**		**Action Plan**		**Whole Process Complete**
		Overdue	***On Target**	**Overdue**	***On Target**	
18/19	**80**	**0**	**0**	**5**	**0**	**75**
19/20	**68**	**0**	**0**	**22**	**0**	**46**
20/21	**50**	**0**	**0**	**20**	**0**	**30**
21/22	**171**	**2**	**0**	**85**	**0**	**84**
22/23	**112**	**18**	**0**	**48**	**4**	**42**
23/24	**129**	**23**	**0**	**67**	**4**	**35**
24/25	**89**	**46**	**0**	**19**	**17**	**7**
25/26	**36**	**21**	**14**	**0**	**1**	**0**
Total	**735**	**110**	**14**	**266**	**26**	**319**
** On Target - within timescales as defined by HIS Framework*						

Table 7: Status of Significant Adverse Event Reviews – Acute Services

No of SAERs Active by Commissioned Date						
Year	**Total No Commissioned**	**Report**		**Action Plan**		**Whole Process Complete**
		Overdue	***On Target**	**Overdue**	***On Target**	
18/19	**21**	**0**	**0**	**0**	**0**	**21**
19/20	**15**	**0**	**0**	**0**	**0**	**15**
20/21	**22**	**0**	**0**	**6**	**0**	**16**
21/22	**19**	**1**	**0**	**8**	**0**	**10**
22/23	**18**	**3**	**0**	**9**	**0**	**6**
23/24	**29**	**9**	**0**	**14**	**3**	**3**
24/25	**33**	**26**	**1**	**3**	**1**	**2**
25/26	**14**	**0**	**14**	**0**	**0**	**0**
Total	**171**	**39**	**15**	**40**	**4**	**73**
** On Target - within timescales as defined by HIS Framework*						

9.1 Adverse Events Key Learning

Work is underway to address the number of overdue action plans particularly in relation to pressure ulcers and falls. The aim is to ensure that outputs from the review of adverse events is more closely linked to improvement work strands.

A dedicated addressing historical LMTRS and SAERS workshop has taken place and identified potential solutions to address the issues faced with the backlog of reviews, identification of lead reviewers and review teams and refine the approval process.

Learning identified through completion of SAER's is developed into an action plan and this is monitored by the appropriate division/service until completion. The themes identified from SAER's approved in recent months are:

- Communication and Documentation
- Clinical Monitoring and Escalation
- Training and Education
- Systems and Processes