Staff wellbeing is overlooked

Blaming culture in the workplace

staff don't know the referral process when consumers need further support.

No Handover

No PPG supports the standard of care

Consumer often hides their thoughts of suicide

Not comfortable asking the question relating to 'suicide'

Consumer left incorrect contact

Not enough support in continuous QI activities

Hard to physically contact consumers post discharge

environment is too noisy and crowed

Lack of communication with community servcies

sumers uncertain about the care plan

Community services do not know the process in escation of care

Not knowing how we are performing now

Staff doesn't feel safe working in MH services

consumer refused help

Hard to get MDT review

Family/Carers are not aware of the care plan

It is impossible to stop consumers thinking of 'suicide'

Management doesn't react promptly on incidents of 'self-harm' when HS is 3 or 4

No time to learn UpToDate skills

No idea on what to Assess in ED

Not enough nurses in care

No Confidence conducting risk assessment

Failed to recognise earlier

miro