

Date	
Time	
Name of Hospital	
Name of Ward	
Type of Ward (high secure/open ward etc.)	

As part of a national programme looking at patient safety in mental health wards in Scotland, we would like to invite you to participate in a survey. The survey will gather your views and experiences on different aspects of safety on the ward to help us make improvements.

How long have you been an inpatient in this ward?	Less than 1 week	
	Between 1 week and 1 month	
	More than 1 month	
	Prefer not to say	
Are you detained under the Mental Health Act?	Yes	
	No	
	Don't know	
	Prefer not to say	
Is this your first admission?	Yes	
	No	
	Prefer not to say	
01	What does safety mean to you?	
	Comments	

Please rate the following by placing a tick under the response that best fits with your experiences from strongly disagree to strongly agree		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
02	I feel safe in the day time.						
	Comments						
03	I feel safe at night time.						
	Comments						
04	I feel safe in the shared areas of the ward.						
	Comments						
05	I feel safe when staff are not obviously visible. For example, handover times or meal times.						
	Comments						
06	I feel the ward is a safe place for people to visit me. For example, my family, children, friends and carers.						
	Comments						
07	I feel safe with the mix of patients on this ward.						
	Comments						
08	I feel safe when there are difficult events on the ward that involve other people.						
	Comments						

Please rate the following by placing a tick under the response that best fits with your experiences from strongly disagree to strongly agree		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
09	I feel confident that staff deal safely with difficult events on the ward.						
	Comments						
10	If I witness difficult events on the ward, staff help me make sense of them.						
	Comments						
11	If I become upset staff support me.						
	Comments						
12	I feel able to express any concerns I have.						
	Comments						
13	If I have concerns, I would know who to go to.						
	Comments						
14	If I have concerns, I feel staff would provide me with the appropriate support.						
	Comments						
15	If I had to be restrained I feel this would be done safely.						
	Comments						

Please rate the following by placing a tick under the response that best fits with your experiences from strongly disagree to strongly agree		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
16	If I witnessed somebody else being restrained I think this would be done safely.						
	Comments						
17	I am involved in making decisions about my medication.						
	Comments						
18	I have received enough information about why I take my medication.						
	Comments						
19	I have received enough information about the side effects my medication may cause.						
	Comments						
20	I feel staff address my physical health issues as well as my mental health.						
	Comments						
21	I feel staff work with me when planning my care.						
	Comments						

Please rate the following by placing a tick under the response that best fits with your experiences from strongly disagree to strongly agree		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
22	I feel there is something about my particular circumstances or lifestyle that affects how safe I feel on the ward. For example, my race, religion, gender, age or sexuality						
	Comments						
23	Can you let us know anything you think would improve the safety of this ward.						
24	What do you do to keep yourself safe?						

*On behalf of the Scottish Patient Safety Programme for Mental Health, thank you for all your help.*

## additional information (to be provided by the facilitator or volunteer)

<b>Your name and organisation:</b>			
<b>Approximate time taken by the patient to complete the questionnaire?</b>	<i>Less than 10 minutes</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>10-30 minutes</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>More than 30 minutes</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>Kept to complete later</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>Not able to complete</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>How much help did the patient need to complete the questionnaire?</b>	<i>Self completed</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>Brief guidance and self completed</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>Guidance during half of the questionnaire</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>Guidance throughout</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Communication – were there any communication difficulties?</b>	<i>Yes</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>No</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Communication – was English the 1<sup>st</sup> language of the patient?</b>	<i>Yes</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>No</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Communication – If 'Yes' please advise if a translator was present and the patients 1<sup>st</sup> language</b>	<i>Yes</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>No</i>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>1st language</i>	<input type="checkbox"/>	<input type="checkbox"/>

(Please tick the relevant box)

**Equality & Diversity Demographics** (The information you provide in this part of the form is for information purposes and will be separated from the questionnaire)

How old are you?	<i>Under 18</i>		<i>45-64</i>	
	<i>18-24</i>		<i>65+</i>	
	<i>25-44</i>		<i>Prefer not to say</i>	
Which one of the following best describes your gender?	<i>Male</i>		<i>Female</i>	
	<i>Prefer not to say</i>			
Do you consider yourself to be transgender?	<i>Yes</i>		<i>No</i>	
	<i>Prefer not to say</i>			
Which of the following best describes your sexual orientation?	<i>Heterosexual / straight</i>		<i>Bi / Bisexual</i>	
	<i>Gay</i>		<i>Lesbian</i>	
	<i>Prefer not to say</i>			
Do you consider yourself to be disabled?	<i>Yes</i>		<i>No</i>	
	<i>Prefer not to say</i>			
If you answered yes, please provide information about your disability:				
What is your religion or belief?	<i>None</i>		<i>Sikh</i>	
	<i>Church of Scotland</i>		<i>Hindu</i>	
	<i>Roman Catholic</i>		<i>Jewish</i>	
	<i>Other Christian</i>		<i>Muslim</i>	
	<i>Buddhist</i>		<i>Prefer not to say</i>	
	<i>Other, please write in:</i>			
What is your ethnicity?				
White	<i>Scottish</i>		<i>Other British</i>	
	<i>Irish</i>		<i>Gypsy / Traveller</i>	
	<i>Polish</i>			
	<i>Other, please write in:</i>			
Other ethnic group	<i>Any mixed or multiple ethnic groups</i>			
	<i>Arab, Arab Scottish, Arab British</i>			
	<i>Other, please write in:</i>			
Asian	<i>Pakistani, Pakistani Scottish or Pakistani British</i>			
	<i>Indian, Indian Scottish or Indian British</i>			
	<i>Bangladeshi, Bangladeshi Scottish or Bangladeshi British</i>			
	<i>Chinese, Chinese Scottish or Chinese British</i>			
	<i>Other, please write in:</i>			
African, Black or Caribbean	<i>African, African Scottish or African British</i>			
	<i>Black, Black Scottish or Black British</i>			
	<i>Caribbean, Caribbean Scottish or Caribbean British</i>			
	<i>Other, please write in:</i>			
<i>Prefer not to say</i>				

## *Acknowledgements*

We would like to thank all those who have worked with us to produce the Scottish Patient Safety Programme for Mental Health Patient Safety Climate Tool.

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