Patient Safety Incident Response Plan (PSIRP)

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Contents

Introduction

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF) as a foundation for change and as such, it challenges us to think and respond differently when a patient safety incident occurs. It is a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP) and sets out how St Helena will respond to patient safety incidents.

PSIRF is designed to promote learning and systemic improvement, moving away from the previous Serious Incident Framework which focussed more on process than emphasising a culture of continuous improvement in patient safety.

This framework is designed to focus on doing investigations in a collaborative way, led by those who are trained to conduct them. It ensures the involvement of patients, their carers, families and staff in an embedded system that responds in the right way, appropriate to the type of incidents and associated factors. It recognises the need to provide a safe and supportive environment for those involved in any investigation, with an emphasis on systemic improvement.

Analysis of our current systems has improved our understanding of our patient safety processes and allowed us to use these insights to develop our PSIRP.

Scope

There are many ways to respond to an incident. Our PSIRP covers responses conducted solely for the purposes of systems-based learning and improvement.
Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.
There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.
Other types of response exist to deal with specific issues or concerns, and it is outside the scope of PSIRF to review matters to satisfy processes relating to these, examples of which may include complaints, HR matters, legal claims and inquests.

Resources

This plan with be supervised by our Risk & Incident Group (RIG), with reporting to our Clinical Governance and Compliance Group. The key staff involved in its implementation will be

- Project Lead: David Traynier, Head of Quality & Compliance
- Executive support: Lisa Parrish, Director Care
- Operational support: Niamh Eve, Inpatient Unit Matron, Nicky Coombes, Hospice in the Home Matron
- Administrative support: Claire Dalling: PA to the Director of Care, Sarah Hay, Clinical Compliance Officer

Defining our patient safety incident profile

We reviewed our patient safety data to determine any priority areas to support the delivery of the new PSIRP. For this, we noted the suggestions on the PSIRP template and considered the sources in Table 1.

Item	Response
Patient safety incidents (state Period)	Reviewed for period 01/04/2020 to 31/03/2023. Total 1169
Serious Incidents (state period)	Reviewed for period 01/04/2020 to 31/03/2024. Total:
GP Quality Alerts (state period)	N/A
Complaints and PALS (state period)	Reviewed for period 01/04/2020 to 31/03/2023.
Legal – Clinical Negligence Claims (state period)	N/A
Legal – Inquests (state period)	N/A
Freedom to Speak Up	N/A
Mortality / Learning from deaths	N/A
Safeguarding	See incidents
Staff survey results	Not reviewed
Risk registers and Board Assurance Framework	Reviewed for period 01/04/2020 to 31/03/2023.
Staff suspensions	N/A
Quality Improvement projects	Clinical audits reviewed for period 01/04/2020 to 31/03/2023.
CQC inspections	N/A (last inspection 2017)

Table 1 Data sources used.

Patient Safety Incidents

An analysis of incidents logged by our Patient & Family Services (PFS) directorate during the period 04/04/2020 to 31/03/2023 returned 1169 records.[1] This data shows that the bulk of incidents (81%) logged during the period comprised low grade pressure ulcers, patient falls, and medicines errors.

While medicines errors are avoidable, as a Hospice we consider pressure ulcers and falls to be an inevitable part of care, despite the measures we take to prevent them.

Pressure Ulcers

We treat all pressure ulcers as incidents, irrespective of category and origin. It should be noted that just 5.4% of pressure ulcer incidents recorded during the period included Grade 3 or 4 ulcers and 47% of incidents reported ulcers were found on admission. At St Helena, pressure ulcers are not generally subject to a root cause analysis style investigation. Instead, the clinical notes relating to each incident are audited to

[1] Note that incidents not affecting patient safety, information governance incidents, and incidents reported as concerning third party providers were excluded from these figures.

determine if any of our standard preventative measures have not been taken. Only new Category 3 or 4 ulcers may merit a PSII.

Falls

Most falls we log are of no or low harm, with just seven of 205 during the period causing moderate harm or more. During investigation, we log the circumstances of the fall and, like pressure ulcers, check whether all the prophylactic measures were in place. We only conduct a root cause analysis for falls where performance issues are suspected, or some other circumstance warrants it.

Medicines Errors

We code medicines errors using the schema created by our Local Intelligence Network. Although our data is not complete, it shows that by far the most common type of medicines error we report (42/126) is of the LIN category 'Administration error - patient taken'.

There are several things we can do to improve our handling of incidents. These include:

- Refresh of incident codes.
- Staff training on incident reporting and management.
- Audits of clinical incident management.

Complaints

A tabulation of PFS complaints and concerns over the period 01/04/2020 to 31/03/2023 returned 121 entries of which 78 were concerns and 39 were complaints.[2] Previously, we have not thematically coded complaints, instead treating them individually. We also have a very small number of complaints per year compared with an Acute Trust, which makes thematic analysis harder. That said, applying a rough ad-hoc coding to these 39 superficially indicates that most commonly complaints concern inadequate clinical care or inadequate communication. However, this analysis does not account for whether a given complaint (or aspect of a multifaceted complaint) was upheld or not.

During Q1 and Q2 of 2024, we will be introducing a new PALS[3]-like complaints service with a Complaints Coordinator role. We also propose to introduce new functionality to our complaints management system to code complaints and responses, to better profile areas of concern. It may also be feasible to introduce natural language analysis for complaints and a post-complaint satisifaction survey. We will also produce a refreshed SOP for complaint handling and enhanced oversight of response letters and investigations.

[2] Complaints concerning external providers were excluded.
[3] Patient Advice and Liaison Service.

Risk Management

For the purposes of this plan, all PFS risks created between 01/04/2020 and 31/03/23 were tabulated. Estates & Facilities risks, individual patient assessments, IT risks, and risks relating to COVID were excluded. Analysis of the remaining 21 risks suggested there is little by way of theme to our risks, because the numbers are relatively low. Medicines safety and record-keeping are the most common types of risk we log.

Risk Management at St Helena has been undergoing an improvement exercise since the beginning of 2023, with a new policy for the organisation, a review of open risks, improvements to our Sentinel Risk Register, a new Risk Assessments module, and a clearer requirement for departments to monitor risks. That said, PFS is the Directorate in need of the least work in this area as its risk management has historically been the strongest. Nonetheless, improvements can be made to the following:

- Risk phrasing
- Risk scoring.
- Action and control phrasing.
- Integration with incident and complaints management.

Freedom to Speak Up

Despite promotion, Freedom to Speak Up engagement has been low at St Helena, with so few issues raised analysis is redundant. Irrespective of this, we will begin handling FSUG activity with a dedicated Sentinel module to improve reporting and integrate better with incidents, risks, and complaints.

Clinical Audit

St Helena had a programme of approximately 190 clinical audits during the period 01/04/20-31/03/2023. According to our records (which are incomplete), none was carried out solely as the result of an incident, although we do have the ability to record that on our Clinical Audit Sentinel module. It is therefore hard to state whether any of our audits was carried out in response to a specific problem, although a handful may have been. The vast majority, however, are carried out to assure that practice is to standard.

We have plans to improve the way we document the result of clinical audits on our Sentinel system, so that we can produce a better overall picture of our strengths and weaknesses.

Staff Training

We will enrol key staff on external training courses, such as HSSIB's 'A systems approach to investigating and learning from patient safety incidents.' These staff will then train their colleagues as required.

We plan to develop a specific incident management competency and will work with our Hospice Education Team to do this, partnering with St Elizabeth Hospice.

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

Table 1 below sets out the local or national mandated responses.

	National priority	Response
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led
3	Maternity and neonatal incidents meeting the Healthcare Safety Investigation Branch (HSIB) criteria	Refer to HSIB for independent PSII
4	Child Deaths	Refer for Child Death Overview Panel review. Locally led-PSII (or other response) may be required alongside the Panel review - organisations should liaise with the panel
5	Death of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII (or other response) may be required alongside the LeDeR review
6	Safeguarding incidents in which: Babies, children and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism; modern slavery & human trafficking or domestic abuse/violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards

7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration or locally led learning response See : Guidance Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)
8	Deaths in custody (e.g. police custody, in prison, etc) where heath provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.
9	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	Locally led PSII by the provide in which the event occurred with STG/ESTH participation if required
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and STG / ESTH participation
11	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria fr a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

Our patient safety incident response plan: local focus

The following table provides general guidance only. Incident Owners and the RIG retail the discretion to apply a PSII to any incident where learning is anticipated.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Failure to follow up	PSII	
Category 1 Pressure Ulcers		Risk & Incident Group and Tissue Viability Group.

All pressure ulcers apart from New Category 3 and 4	Standard mini audit to look for failures in prophylaxis	Risk & Incident Group and Tissue Viability Group.
New Category 3 or 4 pressure ulcers	PSII	Risk & Incident Group and Tissue Viability Group.
Patient falls up to moderate harm	Standard mini audit to look for failures in prophylaxis	Risk & Incident Group and Falls Group.
Patient falls above moderate harm	PSII	Risk & Incident Group and Falls Group.
Medicines errors.	Low harm errors will receive a light touch assessment of the causes and harm involved. Multiple errors of the same type will be subject to cluster analysis. Incidents involving more than moderate harm or where there is susepcted substantial learning will be subject to a PSII.	All medicines errors will be reviewed by the Medicines Management Group or its delegated sub-group.

This PSIRP will have the flexibility to manage emergent risks or new incidents that signify extreme levels of risk or incidents that don't fall into the outlines national or local categories. **{name of organisation]** will take a pragmatic approach and a proportionate response to maximise learning. Any training requirements required to support the delivery of the incident response methodologies chosen in the above table should be included here. There should be a brief explanation of when the training needs are expected to be fulfilled – ie.'by Spring 2024'.

Review of the Plan

St Helena will review this plan every 12-18 months in line with national guidance. If there is a change to the plan, **St Helena** will notify the ICB to agree sign off the change
Where there is a cluster or unexpected significant number of incidents, ICB may ask for an earlier review of the plan as appropriate

Annex 1 - Glossary

PSII - Patient Safety Incident Investigation

PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident

type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

PSIRF - Patient Safety Incident Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

AAR – After action review

A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

Never Event

Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Deaths thought more likely than not due to problems in care

Incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.