Patient safety incident response plan

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Introduction

This patient safety incident response plan (PSIRP) sets out how Barnsley Hospital NHS Foundation Trust (BHNFT**)** intends to respond to patient safety incidents over the next 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This PSIRP is underpinned by our Patient Safety Incident Response policy and supporting documents.

Our services

BHNFT is registered with the Care Quality Commission to provide services in the following locations:

- Acorn Rehabilitation Unit
- Barnsley Hospital
- Community Diagnostic Centre

Defining our patient safety incident profile

The following stakeholders were involved in identifying, analysing and defining BHNFT's patient safety incident profile:

- Staff – through incidents reported on the Trust's incident reporting system
- Patients, carers and their loved ones – through review of the thematic contents of complaints and concerns
- Specialist advisors and leads for organisational data in the Trust
- Medical Examiners service, HM Coroner and the Local Maternity and Neonatal System
- Other key external partners

The Trust's patient safety incident profile was developed through review and analysis of the following organisational data:

Clinical incidents reported 01/01/2021 – 31/12/2022
Patient safety incident investigation reports (serious incidents and high level reviews)
Complaints and concerns
Freedom to speak up reports
Mortality reviews (structured judgement review (SJR))
Case note reviews (women's services)
Staff survey results
Clinical negligence claims
Inquests
NHSR annual maternity trust claims scorecard
Staff suspensions
Risk assessments: • Clinical • Non clinical
Data from quality surveillance processes: • Falls • Tissue viability • Dementia • Venous thromboembolism (VTE) • Sepsis • NEWS2 observations • Healthcare associated infections (HCAI) • Surgical site infections (SSI)
Inequalities data

The PSIRP: local focus includes the patient safety incidents BHNFT has identified through stakeholder analysis of the organisational data that present the greatest opportunities for learning and subsequently improving the safety and quality of care our patients receive.

The Trust has used the criteria below when defining our patient safety incident responses:

- Potential for harm and loss of trust in BHNFT's services
- Impact on quality and delivery of BHNFT's services
- Likelihood and persistency of the incident

- Potential to escalate

Defining our patient safety improvement profile

The Trust's patient safety improvement profile can be found on the Proud to Improve - project list

The Trust's patient safety improvement profile was taken from the Quality Improvement monthly report (June 2023)

Quality improvement project name	Related patient safety theme
Increase in breast screening for LD patients	Diagnosis delay/failure
Improving the diagnosis and management of urinary tract infections (UTI) in patients 65+	
Identifying aortic dissection in ED	
HIV testing in ED	
Improving knowledge on medication	Medication incident
Pharmacy assistant	
Antimicrobial stewardship	
Oxygen prescription & administration	
Improving prescription pick ups	
Reduction in patient deconditioning	Complication of ill health
Clinical Decision Unit (CDU) reconditioning games	
Stroke services	Delay/failure to implement care
Reduction in phone calls in Early Pregnancy Gynaecology Assessment (EPGA)	
Frailty unit	
Clinical frailty score in ED	
Maternity triage system	
Maternity observations early warning score	
Postpartum blood loss	
Chest drain kits	
Reduction in length of stay in patients who have had hip and knee replacements	
Improving the culture of medical handover	
Trauma theatre start time	
Reducing length of stay in ED for paediatric patients with minor head injuries	
Theatre utilisation (emergency, elective, day surgery)	
Enhanced care	
Walking boots in paediatric ED	
Resus training compliance	
Improving acute kidney injury (AKI) bundle compliance	
Patient asthma discharge bundle (paediatrics)	
Medicine ward cover	
Improving early administration of colostrum	
Dysphagia swallow screening	
Reusable PPE	Infection prevention and control
Reducing the inappropriate use of non-sterile disposable gloves	
Reducing pressure ulcers in ED	Tissue viability

Post fall assessment (medical) Post fall nurse assessment in ED	Slips, trips and falls

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.

BHNFT is required to carry out PSII for incidents meeting the NHS England never events criteria 2018 (updated February 2021) and deaths clinically assessed as more likely than not due to problems in care.

The table below sets out the events that a national mandated response is required for. It is more likely that the Trust will contribute to, rather than lead the investigations for the events numbered six to eleven.

	National priority	**BHNFT response**
1.	Incidents meeting the never events criteria	BHNFT led PSII
2.	Deaths clinically assessed as more likely than not due to problems in care	BHNFT led PSII
3.	Incidents in NHS screening programmes	BHNFT led PSII in line with guidance for managing safety incidents in NHS screening programmes
4.	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) in line with BHNFT learning from deaths policy
5.	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 (BHNFT learning from deaths policy)	BHNFT led PSII in line with BHNFT learning from deaths policy
6.	Maternity and neonatal incidents meeting the Maternity and Newborn Safety Investigations (MNSI) criteria	Refer to the MNSI for an independent PSII
7.	Safeguarding incidents in which: • babies, child 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	Refer to local authority safeguarding lead. BHNFT must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local

	• the incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Safeguarding Partnership (for children) and local Safeguarding Adults Boards.
8.	Child deaths	Refer to child death overview panel for review
9.	Mental health related homicide	Refer to the NHS England Regional Independent Investigation Team (RIIT) for consideration of an independent PSII
10.	Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	Refer to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigation
11.	Domestic homicide	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 for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel

Our patient safety incident response plan: local focus

BHNFT considers that the incident types set out below are key to delivering high quality, person centred care. The PSIRP aims to support and embed the Trust's ongoing quality improvement (QI) work.

Incident type	Description	Learning response
Patient harm (excluding death)	Incidents resulting in patient harm (excluding death) as a consequence of missed/delayed recognition or escalation of diagnosis or treatment where new system based learning is identified	Patient safety incident investigation (PSII)
Digital systems	Incidents as a result of the use of BHNFT's digital systems that have the potential for harm, loss of trust or an impact on quality and delivery of services where new system based learning is identified	PSII
Repeated incident identified	A source* (e.g. corporate lead, group, committee, complaints, incidents litigation, inquests, maternity dashboard etc.) identify the same issues in three investigation/responses when improvement work is known to have been implemented	PSII
Patient involvement	Where patients or their loved ones questions would not be fully answered by the proposed learning method or other Trust process* (e.g. complaint, litigation, subject access request etc.)	PSII

*not an exhaustive list

All proposed PSII will be escalated for discussion and agreement at the Trust's weekly Patient Safety Panel chaired by the Medical Director/Director of Nursing, Midwifery and AHPs.

Where a patient safety incident does not fall into any of the above categories a learning response will be undertaken in line with the relevant Trust policy/SOP. Links to the relevant SOPs are included in appendix 2.

Where there is no Trust policy/SOP that sets out a learning response a narrative response should be updated on the incident report following a local investigation or one of the learning responses included in appendix 1.

Appendix 1 – learning response methods

Learning response method	Description
Patient safety incident investigation (PSII) Suggested duration – 20 to 80 hours over several weeks Undertaken by a trained patient safety investigator Report generated	An in depth review of a single incident or cluster of incidents to understand what happened and how
Multidisciplinary team review (MDT) No suggested duration Led by a clinical governance facilitator/investigation officer	Supports teams to learn from multiple incidents or a safety theme that occurred in the past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. Uses an open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle Suggested duration – 30 minutes Chaired by a senior lead Report generated	A meeting initiated as soon as possible after an incident. Staff 'swarm' to the site to gather information about what happened, why it happened and decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR) Suggested duration – 45 – 90 minutes Led by an appropriate facilitator Lessons learnt log generated	A structured facilitated discussion of an incident that gives individuals involved in the incident understanding of why the outcome differed from that expected and the learning to assist improvement. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?

Appendix 2 – Trust policies/SOPs relating to learning responses

Incident management policy

Womens services quality, safety and governance

Learning from deaths policy

Surgical site infection RCA process (appendix 6 in incident management policy)

Falls prevention policy

Pressure ulcer prevention policy

VTE prevention policy

Clostridioides difficile policy

Hospital onset covid-19 infection SOP

Management of healthcare associated infections SOP