Patient safety incident response plan

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	NAME	TITLE	SIGNATURE	DATE
Author	Paul Chandler	Head of Patient Safety & Quality Assurance.		16/06/2023
Reviewer	Executive Management Team			20/06/2023
Authoriser				

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Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how the Royal Hospital for Neuro-disability (RHN) intends to respond to patient safety incidents over a period of 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. There are four main incident responses that can be considered under PSIRF when patient safety incidents occur:

- A **SWARM Huddle** is an immediate response to a safety incident, where a group discussion occurs to understand what happened and why. Actions are agreed and implemented to mitigate the risk of recurrence.
- A **MDT (Multi-Disciplinary Team) Review** takes place to review a number of similar incidents or an incident where multiple patients were affected. A group discussion takes place to analyse contributory factors and gaps in systems. Events may have occurred sometime previously.
- An **After Action Review (ARR)** is a review of an activity or event that has been either very successful or very unsuccessful. Its aim is to either promote success or avoid failure in the future by capturing the learning from an unexpected outcome.
- A **Patient Safety Incident Investigation (PSII)** is a detailed investigation, undertaken when an incident or near miss indicates significant safety risks and/or potential for significant new learning. The goal is to understand the interconnected causal factors that lead to a patient safety incident and how systems in place affected it.

Other tools that can be used under PSIRF (Patient Safety Incident Response Framework), either singly or as part of a patient safety investigation / review are:

- **Observation**, where an individual or team observe how staff complete 'work as done' (how they complete activities in the real world) as opposed to 'work as imagined' (how tasks are prescribed in policy and procedure). Observation can be completed over time to understand how different staff complete the same task and whether there are differences in performing a task at different times of the day.
- **Walkthrough Analysis** is a structured approach to collecting and analysing information about a task or process or a future development (e.g. designing a new protocol). It can be used to help understand how work is performed and aims to close the gap between work as imagined and work as done to better support performance.
- **Link Analysis** is a review of a healthcare environment to optimise usability and safety of the space. An example is a review of a ward medications room to ensure maximum use of storage, ease of stock control and efficiency in medication preparation.

- **Horizon Scanning** is a method for an organisation to look ahead and plan to mitigate future risks, such as staffing, or introduce a new service.
- **Thematic Reviews** review can identify patterns in data to help answer questions, show links or identify issues. They can be used to review incident types over time to identify gaps and recommend improvement (deep dives).
- **Quality Improvement Projects** are continual actions to improve patient care and to develop a workforce that supports patients using systematic methods. Actions are agreed and assigned to project team members with defined completion dates that are monitored over time. An MDT approach is mostly used.

The RHN is committed to improve patient safety through the adoption of the PSIRF, supporting a systematic, compassionate and proficient response to patient safety incidents; embedded in the principles of Just Culture (openness, honesty and fair accountability), shared learning and continuous improvement.

In line with the NHS Patient Safety Strategy (2019), patient safety is about maximising the things that go right and minimising the things that go wrong. While patient safety incidents are rare, the RHN prioritises compassionate engagement with patients, family and staff affected by them. This provides vital insight into how to improve care, ultimately making services safer for our patients and residents.

Our services

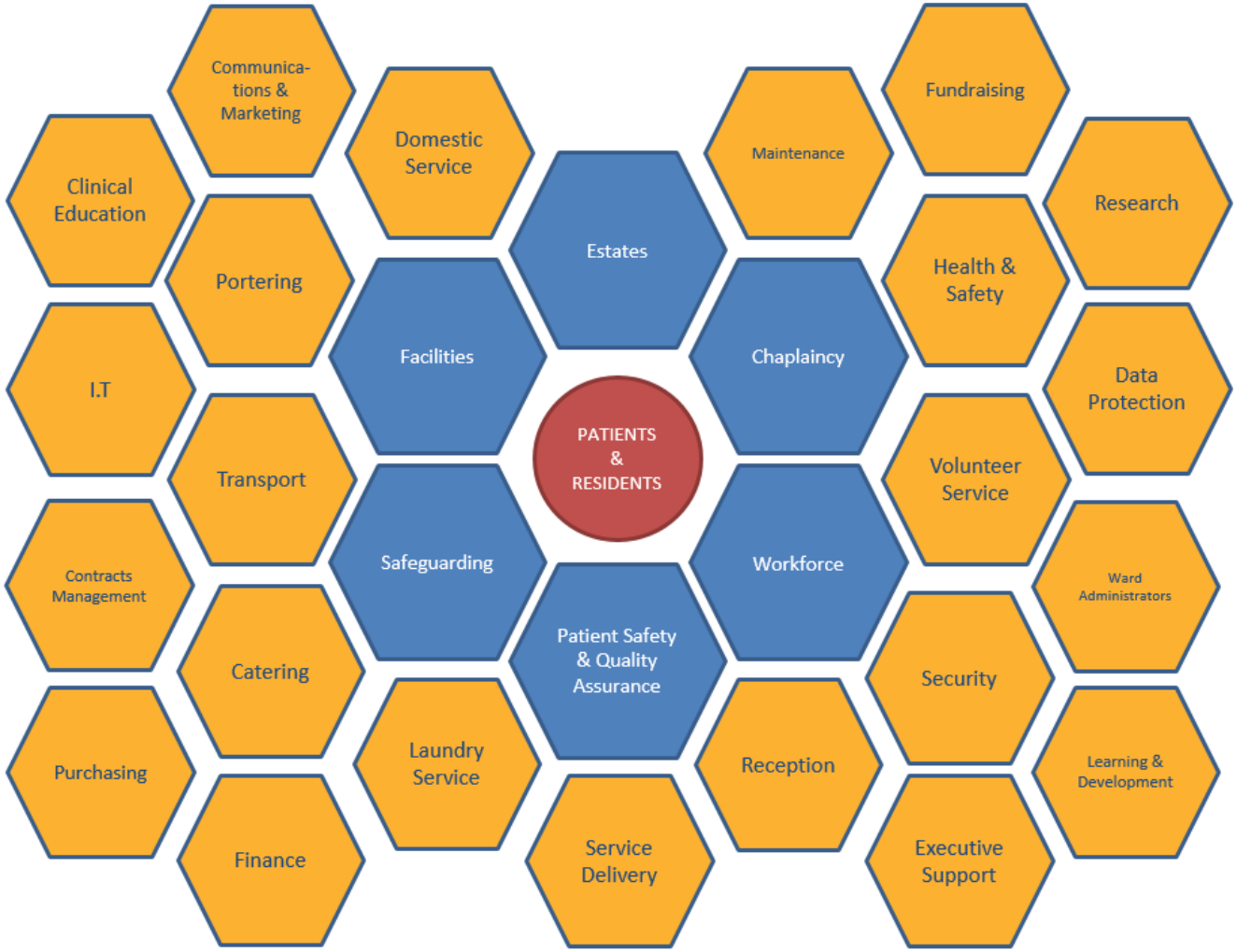
This section sets out the six main services that are provided to patients and residents at the RHN and all the other services that contribute to their care. They have been described as:

- Clinical services.
- Non-clinical support services.
- Non-clinical services.

It is our belief that at the RHN all staff, regardless of their role, contribute to the excellent care that our patients and residents receive.

1. Clinical Services

2. Non-Clinical Support Services



Defining our patient safety incident profile

The RHN's patient safety incident profile has been built by analysing data from the following sources:

- Serious Incidents reported from 01/01/2018 – 31/12/2022 (5 years).
- Internal Root Cause Analysis (RCA) investigations from 01/01/2018 – 31/12/2022 (5 years).
- Safeguarding Referrals from 01/01/2020 – 31/12/2022 (3 years).
- Incidents reported from 01/01/2020 – 31/12/2022 (3 years).

Serious incidents and internal RCAs were reviewed over a 5-year period because as a small organisation with defined services the risks of serious incidents occurring are smaller than a large NHS acute Trust, for example. Thus, the number of incidents occurring each year that either met the criteria for reporting as a serious incident or investigating in more detail as an internal RCA were relatively small. Thus, a 5-year period provided a better wealth of information for analysis than a 3-year period would have.

A 3-year period of review was defined for the review of Safeguarding referrals and incidents reported on Datix (our internal system used mainly for incident management) because this was a period of great change and improvement in patient safety and safeguarding systems and processes at the RHN. We also introduced Just Culture (in 2020) and significantly increased the use of 'deep dive' thematic analysis and quality improvement projects during this period. A 3-year period also provided enough data to be able to complete a detailed analysis.

In order to understand the different methods of incident response that have been used over a total of 5 years the following information was also used:

- Deep dive' thematic analysis.
- Quality improvement projects and their outcomes.
- Service review.

The review also analysed whether incident responses, such as serious incidents, were connected to other management methods, such as safeguarding referrals to the Local Authority, or sparked wider pieces of work, such as quality improvement projects. The incident response method outcomes were also analysed to understand whether individual actions were concluded, such as retraining and reflection, or whether systems related actions were concluded, such as the introduction of a new patient monitoring system.

1. Review of Serious Incident Investigations 2018 – 2022 (5 years)

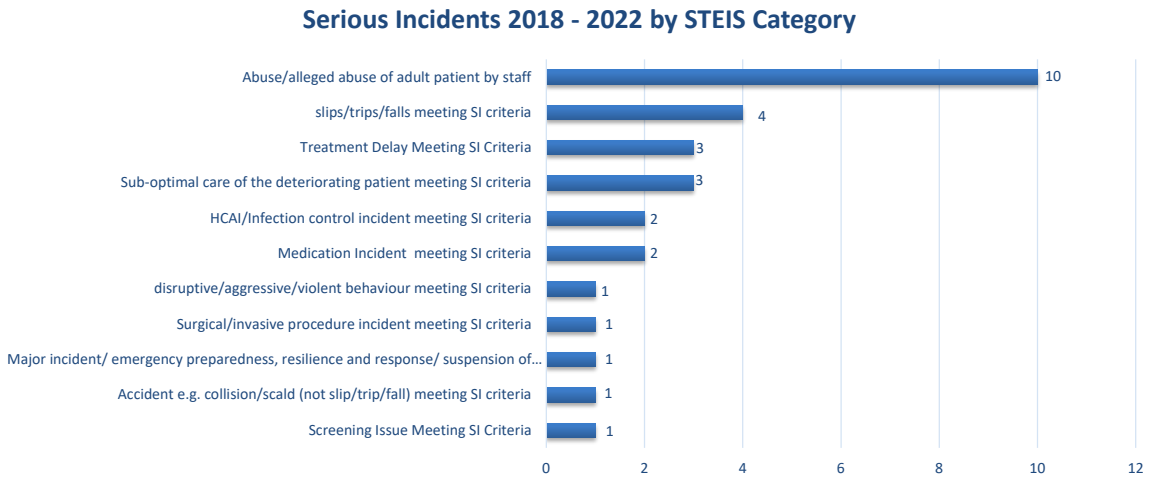


Chart 1

When looking at the STEIS categories that SIs have been declared as (29 in total) the top 4 incident types were:

- Abuse/alleged abuse of adult patient by staff.
- Slips/trips/falls meeting SI criteria.
- Treatment Delay Meeting SI Criteria.
- Sub-optimal care of the deteriorating patient meeting SI criteria

However, there can be a number of different incident types that can fall under the same STEIS category, and so the same incidents were reviewed under their main 'topic' and the following results were seen:

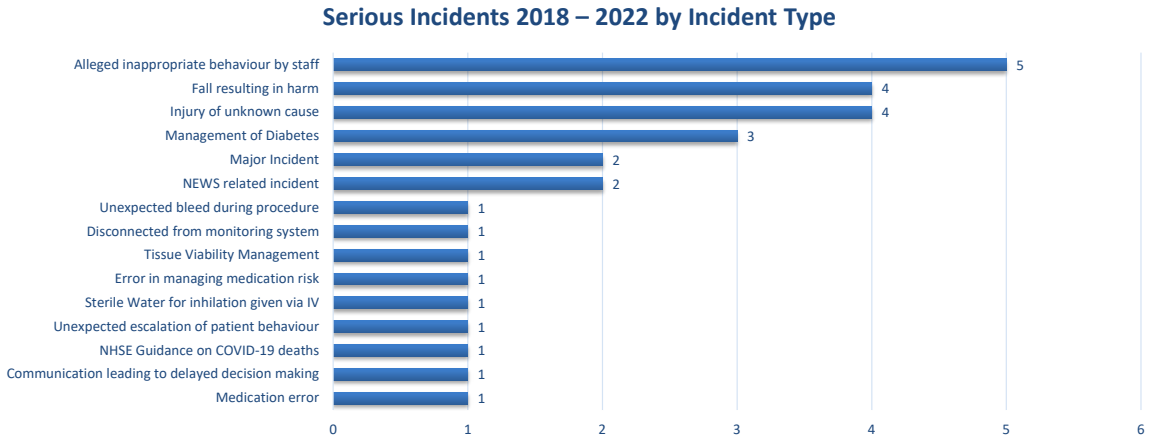


Chart 2

Chart 2 demonstrated that the top 4 serious incident 'topics' were:

- Alleged inappropriate behaviour by staff.
- Fall resulting in harm (to a patient).
- Injury of unknown cause.
- Management of Diabetes.

Thus, the investigation reports (16) of these 4 'topics' were analysed and the following were concluded:

- Of the 16 serious incident investigations completed 13 were also used to inform safeguarding referrals to the Local Authority.
- 8 serious incidents were reported externally due to the opportunity for valuable learning rather than the level of harm caused.
- 4 serious incidents were also used to identify the need for 2 quality improvement projects:
    - One to improve support provided for Healthcare Assistants, and ultimately improve the care they provide to patients and residents.
    - One to improve the care of patients and residents with diabetes.
- 2 serious incidents indicated the need for a review of the assessment and care of patients and residents at risk of falling. This resulted in a significant decrease in the number of patients who sustain serious injury as a result of falling at the RHN.
- 8 serious incidents adopted a systems approach when drawing their main conclusions and actions.

2. Review of Internal RCA Investigations 2018 – 2022 (5 years)

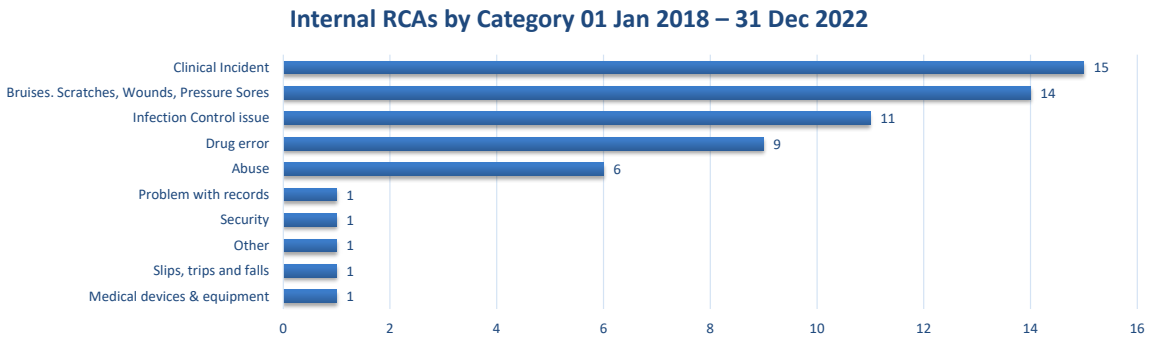


Chart 3

The top 5 Incident categories were:

- Clinical Incident.
- Bruises, scratches, wounds, pressure sores.
- Infection Prevention & Control issues.
- Drug errors
- Abuse (alleged).

The investigation reports (62) for each top category were analysed and the following conclusions were made:

- Most incidents investigated as internal RCAs had resulted in low or no harm.
- There was evidence in the use of a systems approach when drawing their main conclusions and actions.

3. Review of Internal Safeguarding Investigations 2020 – 2022 (3 years)

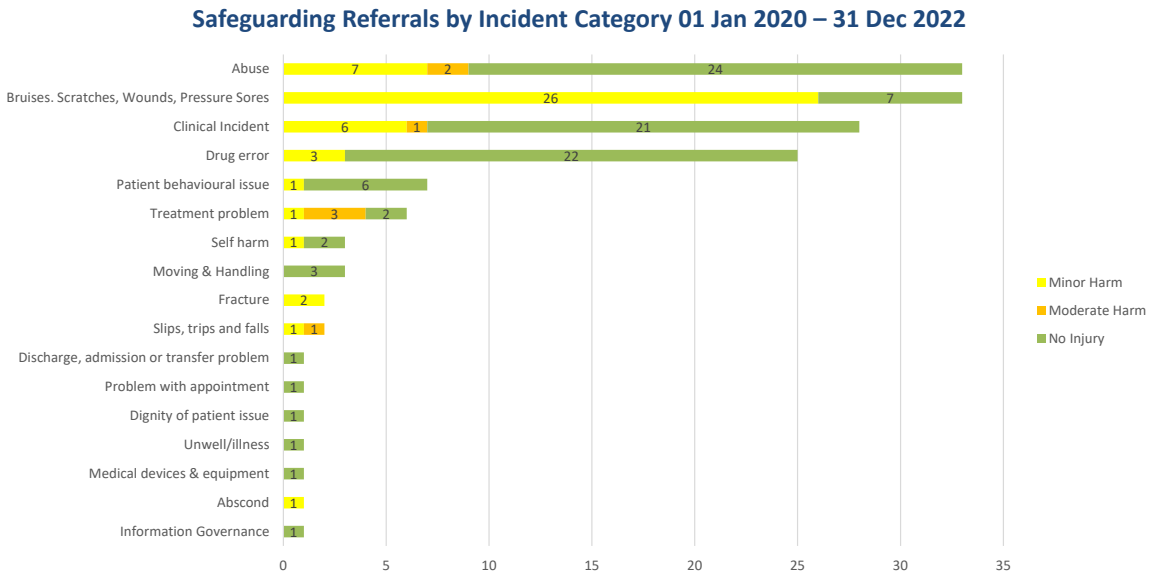


Chart 4

When looking at safeguarding referrals and their incident categories the top 4 incident types were:

- Bruises, scratches, wounds, pressure ulcers:
  - Skin integrity issues meeting a safeguarding referral threshold.
  - Pressure damage acquired from an external provider referred in relation to their care
- Abuse:
  - Alleged abuse raised to staff by patients / residents.
  - Alleged abuse raised to staff by visitors / family.
  - Alleged abuse of patients raised by staff.
- Clinical Incident:
  - Tube related incidents meeting the safeguarding referral threshold.
- Drug error:
  - Medication omissions.
  - Medication given to the wrong patient.
  - Signature omissions in EPR causing a medication over / under dose.

The investigation reports (119) for each top category were analysed and the following conclusions were made:

- The following investigation methods were used:
  - Safeguarding investigations including those for Section 42 enquiries.
  - Serious incident investigations RCA (12)
  - Internal RCA (24)
- 15 incidents were reported externally as Serious Incidents from 2020 – 2022
- 12 (80%) of the 15 Serious Incidents were also referred to the Local Authority as Safeguarding concerns.
- The top 3 serious incident categories were:
  - Treatment problems (4).
  - Drug errors (2).
  - Clinical incidents (2).
- 4 of the 8 serious top 3 incident categories investigated had resulted in low or no harm, and so were reported as serious incidents due to their potential for learning rather than harm caused.
- There was evidence in the use of a systems approach when drawing their main conclusions and actions.

4. Review of Incidents Reported 2020 – 2022 (3 years)

	No Harm	Minor Harm	Moderate Harm	Total
Bruises. Scratches, Wounds, Pressure Sores	281	804	0	1085
Clinical Incident	944	46	5	995
Drug error	917	13	0	933
Patient behavioural issue	605	158	0	763
Slips, trips and falls	421	74	1	496
Laundry	308	0	0	308
Moving & Handling	155	37	0	192
Staffing Issue	184	2	0	186
Information Governance	179	0	0	179
Abuse	166	8	0	174
Total	**4160**	**1142**	**6**	**5311**

Chart 5: Top 10 Incident Categories

The incidents (5311) for each top 10 category were analysed and the following conclusions were made:

- Incident management and investigation methods used were:
  - Screened for potential safeguarding issues, potential serious incidents and potential RIDDOR reportable incidents at a weekly Potential SI/Safeguarding meeting.
  - A random selection were included in a quarterly Safeguarding Referral Decisions Audit, which is an external peer review audit of the RHN's referral decisions. They have resulted in 95% - 100% compliance with RHN safeguarding related decisions.
  - The majority were managed via local review with an RCA approach.
  - 15 incidents were managed as Serious incidents.
  - 59 incidents were managed as Internal RCAs

- Safeguarding investigations.
- Deep dive thematic reviews into:
  - Pressure related incidents.
  - Respirator and Tracheostomy incidents.
  - Enteral Incidents.
  - Unexplained incidents of tube displacement.
  - Diabetes incidents.
  - Medication related incidents.
  - Falls incidents.
- Quality improvement projects for:
  - Care of patients / residents with diabetes.
  - HCA support and care.
  - 1:1 Care Quality Improvement project.
  - Review of Patient and Staff Injuries in Wellesley Ward.
  - Laundry services and processes quality improvement project.
- Ward Medicines Management Systems Review led by Pharmacy (2022)

- Investigation outcomes used for hospital wide shared learning:
  - SIs and internal RCAs.
  - Safeguarding investigations.
  - Low / no harm incidents identified for shared learning.
  - Shared learning discussed at the SW London Patient Safety Steering Group.
  - HSIB and national investigations relevant to RHN services.

5. Conclusions

	Incident Management Method Applied						
Incident Type	Local Review	Internal RCA	Serious Incident	Safeguarding	Thematic Review	Quality Improvement Project	Shared learning
Abuse	☑	☑	☑	☑		☑	☑
Slips, trips and falls.	☑		☑	☑	☑		☑
Clinical Incident	☑	☑	☑	☑	☑	☑	☑
Bruises. Scratches, Wounds, Pressure Sores.	☑	☑	☑	☑	☑		☑
Drug error	☑	☑	☑	☑	☑	☑	☑
Treatment problem	☑		☑	☑		☑	☑
Infection Prevention & Control issues.	☑	☑	☑		☑		☑
Patient behavioural issue	☑		☑	☑		☑	☑
Laundry	☑					☑	☑
Moving & Handling	☑			☑			☑
Staffing Issue	☑						☑
Information Governance	☑						☑

Chart 6: All the Incident Categories Identified in the Study

Chart 6 outlines the main incident categories that were identified and analysed in previous sections and the different incident management methods that were applied. It demonstrated that a wide variety of incident response methods had been used over the 5-year period reviewed. It also showed that the following methods that align with PSIRF methodology had already been embedded in RHN practice:

- Thematic reviews.
- Quality Improvement
- Shared learning.

Defining our patient safety improvement profile

The RHN has recently published its organisational strategy for the five years 2022-2027 'The Path to Excellence'. It sets out how the RHN will place patient care at the heart of all we do and be the 'go to' place for neuro-disability expertise, making it a place of choice for our patients, prospective staff and referring commissioners. The strategy focusses on the five years 2022-2027. This has been a collaborative process with trustee workshops, discussions with the executive and work carried out by staff at all levels in 2021/22. The trustees adopted the strategy at the board meeting held in October 2022. The strategy embraces the whole of the RHN, with the golden threads of our patients and our people running through the strategy. Underpinning it will be departmental strategies, with detailed action plans.

The RHN has a comprehensive programme of patient safety improvement across the organisation, as well as an active Quality Improvement programme. The clinical governance framework enables a robust assurance process, providing assurance that improvements are made, embedded and sustained.

The RHN works collaboratively with our colleagues across the South West London Integrated Care System to improve patient safety.

The improvement and service transformation work with an impact on patient safety underway or planned across the RHN are:

- Ensure that we have the best mix of clinicians with excellent competencies and access to expert training and wellbeing support.
- Provide services which consistently deliver up to date evidence based practice.
- Deliver a focused programme of research and innovation and share our knowledge and expertise.
- Provide leadership in the development of national policy and standards in neuro-disability.
- Our ventilation service provides long-term respiratory care and support for patients with neurological disabilities. We will:
    - provide strong leadership in long term ventilatory support
    - develop our expertise through advanced clinical practice and the creation of new nursing roles, though nurse apprentices and nursing associates.
    - deliver research to understand how to enhance quality of life for patients who require long term ventilation support and contribute to national standards
    - provide care for more patients with ventilatory needs increasing the number of inpatient beds by 30%.
- Our Brain Injury service provides rehabilitation and assessment for patients with complex neurological disabilities. We will:
    - enhance our expertise across all staff groups
    - deliver a research programme focused on service and pathway innovation
    - access technologies which support enablement
    - provide rehabilitation for more patients increasing our number of inpatient beds by 25%.
- We provide support for patients with disorders of consciousness both within our brain injury service and specialist nursing home. We will:
    - we will enhance our expertise through structured education plans

  - develop pre-admission and post-discharge pathways for patients with disorders of consciousness
  - undertake more research and provide strong national leadership in disorders of consciousness
  - develop and embed processes to ensure that decisions are always taken in a patients' best interests.
- Our Specialist Nursing Home provides long-term care and support for patients with highly complex neurological disabilities. We will
  - review in detail the needs and desires of our residents and those close to them. We will develop the appropriate skills mix to meet their needs.
  - transform our care, support and environment to enable greater personal choice and more opportunities for participation in leisure and therapeutic activities
  - enhance the health, wellbeing and quality of life of our residents.
- Our Neuro-behavioural service provides assessment, rehabilitation and support for patients with challenging behaviours as a result of neurological impairments. We will:
  - develop a range of care pathways which better meet the needs of our patients.
  - develop systems of support which enable more patients to safely return to their local communities.
  - provide care and support for more patients with neuro-behavioural issues, increasing the number of inpatient beds by 30%.
- Our newly developed service for young adults provides care and support for patients with
- complex disabilities. We will:
  - Grow our expertise to meet the needs and aspirations of young adults with complex neurological disabilities
  - Develop an enabling and homely environment.
  - Provide more care and support for young adults, increasing the number of residential places by 50%.
- Our Compass Assistive Technology service provides assistive technologies for patients with neurological disabilities. We will:
  - Enhance the provision of assistive technologies for patients at the RHN
  - Assess outcomes and contribute to the evidence base for assistive technologies
  - Pilot systems of remote rehabilitation.
  - Grow our service provision outside of the RHN by 10%.
- Through our Patient & Resident Experience and Engagement Strategy will:
  - Source customer service / communication training from a recognised body. The RHN will also gain accreditation in this area.
  - Introduce electronic feedback stations placed at specific locations in the hospital to enable service users to provide regular feedback on 'how was your visit today' and themed areas of care or service over time. We will also develop an audit on the Tendable audit application (app) to enable staff to regularly seek feedback from patients, residents, their families and advocates on 3 key regular questions and 3 other changeable questions around themes or issues that have been identified.
  - When introducing electronic feedback stations or a patient / resident experience audit on the Tendable audit application (app) we will involve the SALT team to ensure that those with complex communication needs have the opportunity to give more regular feedback. This may include the use of the Tendable app, EPR and Power BI Reports to capture 'feedback in the moment'. We will also consider

implementing ‘observe and act’ training provided by an NHS Community Trust as a method of capturing ‘feedback in the moment’.

- We will complete a quality improvement project around ward notice boards and TV screens; and how they can be most effectively utilised. The project will include a review of Quality Board information, including ‘You said - We did’. We will also link with the Communications, Information Technology and Fundraising teams to consider the introduction of a hospital radio system, further develop our use of podcasts and social media in communicating information to our patients and residents in a way that captures their interest.
- We will complete a quality improvement project around new patient / resident information and how they can be most effective. The project will include a review of Quality Board information, including ‘You said - We did’. We will also link with the Communications, Information Technology and Fundraising teams to consider the use of a hospital radio system, podcasts, website and social media in assisting new patients and residents to orientate to the hospital in a way that captures their interest.
- We will work together to regularly review the signage around the hospital and ensure it is simple and helpful.
- Patient and Resident stories will be included in Board meetings and staff induction. This will be a welcome from patients and residents to inform staff what is important to them.
- We will offer patients and residents opportunities to create shared learning documents from their experiences and opportunities to be involved in leading Putney Board huddles where they are discussed.
- support patients, residents, their families and advocates to lead quality improvement projects as a part of learning from feedback.
- We will review and improve our methods for acting on feedback so that it is more structured and better evidenced. Our patients, residents, their families and advocates will inform how we move forward.
- We will review and improve our methods for encouraging and responding to feedback positively, so that patients, residents, family members and advocates can feel reassured that when they raise a concern it will not impact negatively on care.
- Finalise a project being completed in relation to building therapeutic relationships. This is a project to engage and involve patients, residents and their families in planning their care. It is also a way to gain feedback on their experiences and improve communication.
- Finalise a project being completed in relation to personalising patients’ and residents’ rooms. This is a project to make patients’ and residents’ rooms more personal and homely, including for those who may not have families or advocates who know them.

- We want to have efficient, well-designed and well-maintained land, buildings and equipment that provide a positive patient experience and ensure our patients receive the best possible care. The Estates strategy will support our commitment to environmental sustainability and provide the infrastructure for the delivery of future clinical and service strategies.
- Facilities at the RHN is a mixture of in house and outsourced services. We aim to deliver value and efficient non-clinical support services to patients, staff and visitors. We will engage regularly with our users, stakeholders and suppliers and agree standards and levels of service

for the purposes of delivering user satisfaction and/or compliance such as implementing improvements to patient menus, operating cleaning quality assurance systems and compiling evidence to support CQC observations that “clinical areas are visibly clean”. We will regularly market test to ensure the best and most efficient service is provided.

- We will transform direct communication and embrace opportunities for technical integration of data to improve quality of care. We will take every opportunity to integrate business processes to remove duplications, optimising support services to operate with market leading efficiency and ensure our systems are resilient and continuous.
- We aim to return to sustained surpluses and achieve a cash surplus of 10% of turnover by 2027, to be able to reinvest in the hospital. We will compare ourselves with benchmark data from similar organisations to make ourselves as efficient and competitive as possible whilst not losing sight of the need to invest in our patients, equipment and infrastructure thereby enabling an excellent healthcare setting.
- Through our People Strategy we will:
    - Use values based recruitment processes and assessment centres.
    - Empower our people to improve the delivery of our services.
    - Establish development programmes for staff at all levels that provide upskilling, shadowing, coaching, and provide leadership and management training.
    - Extend our successful apprenticeship programme
    - Look to improve the work-life balance for staff including flexible working and reinvigorating initiatives such as staff social activities.
    - Encourage a culture where work breaks and rest days are seen as a contributor to both staff and patient safety and wellbeing.

Our patient safety incident response plan: national requirements

The following table identified the incident types that could potentially occur at the RHN and their response methods, based on national guidance:

Patient safety incident type	Required response	Lead body for the response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	The RHN	Create local organisational actions and feed these into the quality improvement strategy. Monitored via CQRG (Clinical Quality Review Group) and the Patient Safety & Quality Committee.
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	The RHN	Create local organisational actions and feed these into the quality improvement strategy Monitored via CQRG (Clinical Quality Review Group), the Mortality Review Committee and the Patient Safety & Quality Committee.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – where the death is thought more likely than not due to problems in care.	LeDeR programme	Respond to recommendations as required and feed actions into the quality improvement strategy. Monitored via CQRG (Clinical Quality Review Group), the Mortality Review Committee and the Patient Safety & Quality Committee.
Safeguarding adults at risk incidents.	Refer to SW London local authority safeguarding team	SW London Local Authority team in	Respond to recommendations as required and feed

Patient safety incident type	Required response	Lead body for the response	Anticipated improvement route
	Safeguarding investigation for low or no harm incidents. PSII – for incidents where moderate harm or greater has been caused or where there is potential for significant learning.	collaboration with the RHN.	actions into the quality improvement strategy. Monitored via CQRG (Clinical Quality Review Group), the Safeguarding Assurance Committee and the Patient Safety & Quality Committee.
Notification of Infectious Diseases.	Refer to Public Health England. Local review and/or SWARM huddles for low or no harm incidents involving one patient. MDT review for incidents where low or no harm has resulted and where 2 or more patients are involved. PSII – for incidents where moderate harm or greater has been caused or where 2 or more patients are involved.	The RHN	Respond to recommendations as required and feed actions into the quality improvement strategy. Monitored via CQRG (Clinical Quality Review Group) and the Patient Safety & Quality Committee.

Our patient safety incident response plan: local focus

Chart 7 identified the other incident types that could potentially occur at the RHN and their potential response methods, based on the results of our incident profile:

	Incident Type					
Incident Management Method Applied	Low / No Harm Incident	Harm Incident – Moderate or higher	Incident where significant learning is anticipated (regardless of harm)	Deaths not thought to have been due to problems in care	Information Governance	Incident Clusters (e.g. falls, medication, enteral tubes, diabetes, behaviour, tissue viability)
Local Review	☑				☑	
SWARM Huddle	☑	☑	☑		☑	
MDT Review					☑	☑
After Action Review (ARR)	☑				☑	
PSII		☑	☑		☑	☑
Safeguarding	☑				☑	
Structured Judgement Review				☑		
Thematic Review						☑
Horizon Scanning					☑	☑
Quality Improvement Project.						☑
Externally reported / reviewed					☑	
Shared learning	☑	☑	☑	☑	☑	☑

Chart 7

All incident responses and their resulting actions will be monitored via the CQRG and the Patient Safety & Quality Committee, except for Information Governance related incident responses, which will also be monitored via the Information Governance Committee.