Patient safety incident response plan

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Introduction

This patient safety incident response plan sets out how Wirral University Teaching Hospital 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.

This plan has been built upon a review of the PSIRF expectations, along with the approaches taken and learning identified during recent years under the Serious Incident Framework. The intention within this plan is to provide an efficient but thorough approach to patient safety response, allowing areas for improvement to be identified through the most proportionate responses and ensure sufficient capacity remains for priority quality improvement.

Our services

The Trust provides a wide range of inpatient and outpatient services. Clinical Services are aligned into five clinical divisions; Acute Division, Medicine Division, Surgery Division, Diagnostics and Clinical Support Division and Women's and Children's Division. There are also services provided through Estates, Capital and Facilities Division and Corporate Division, whilst these are not clinical services some will have patient facing components and could be subject to Patient Safety Incidents.

The PSIRF Implementation group has included wide engagement both in relation to the core response plan and also the need for additional sub sections to describe interactions with other local or national response requirements.

The Trust response plan describes the sub sections under the local focus section of this plan.

Defining our patient safety incident profile

The Trust has considered the patient safety incident profile through a combination of existing thematic reviews and through a bespoke review of historic data. Stakeholder engagement has been key both in the review of existing thematic reviews discussed with internal leaders and commissioners quarterly but also through discussion at the PSIRF implementation group involving internal leaders and external partners from Healthwatch.

The initial stage to consider further investigation will align largely to the current triggers for Rapid Reviews. Whilst the current Serious Incident Framework focusses on level of harm, the Trust has already implemented an approach to completion of Rapid Reviews where significant learning potential or risk presents. This is supported by the low conversion rate from Rapid Review to Serious Incident. The Rapid Evaluation of Care process will be triggered by similar routes; actual harm (Moderate or above), potential harm during risk assessment (Moderate or above) and Learning Potential. The basis of this plan is that Rapid Evaluation of Care will be enacted at a similar rate to current Rapid Reviews. During 2022/23 the Trust completed 207 Rapid Reviews across the 5 Clinical Divisions; Medicine (46), Acute (46), W&C (47), Surgery (52) and D&CS (16).

The planning anticipates approximately 50 Rapid Evaluation of Care cases within each of; Medicine, Acute, W&C and Surgery and around 20 within D&CS and with a further understanding that some of the services under Estates Division can impact directly on Patient Safety and anticipation of a further 10 cases via Estates has been planned. This would take the total expected number of Rapid Evaluation of Care cases to 230 per year.

Incidents reviewed under the Serious Incident Framework have identified; 43 Serious Incidents in 2019/20, 41 Serious Incidents in 2020/21, 56 Serious Incidents in 2021/22, 33 Serious Incidents in 2022/23 and 9 Serious Incidents in Q1 2023/24.

There were some clear reasons identified for the increased number of Serious Incidents in 2021/22 with 7 incidents directly relating to COVID-19 and 10 relating to aspects of deteriorating patient. The incidents relating to COVID-19 were largely factors outside of the Trust control and the incidents relating to deteriorating patients were a theme noted and significant work has already progressed in this area. It remains a quality improvement priority and the number of Serious Incidents relating to aspects of care for deteriorating patients reduced to 3 during 2022/23.

This review has concluded that there is anticipated to be 30 – 40 incidents each year where the Serious Incident Framework would have warranted an investigation, in addition the Trust has already initiated internal investigations for those incidents with learning potential but not resulting in sufficient harm to trigger Serious Incident reporting. In 2022/23 this totalled 12 incidents.

Looking forward the anticipation is that the Trust will seek to complete further investigations into 50 incidents via; Thematic Review, Facilitated Reflective Sessions or Patient Safety Incident Investigations.

Of the incidents identified above (182) there are common themes including;

- Falls, accounting for 37 incidents.
- Identification and management of a deteriorating patient, accounting for 16 incidents (although 10 were in 2021/22)
- Maternity and Obstetrics accounted for 15 incidents with 7 incidents reported due to HSIB referrals.
- Imaging issues, accounting for 13 incidents
- Anticoagulation management, accounting for 5 incidents
- Management of patient's mental health needs, accounting for 5 incidents
- Prevention of Pressure Ulcers, accounting for 9 incidents.

The Patient Safety Steering Groups discussed further below are anticipated to respond to most of these incidents via Thematic Review and those reported to HSIB will be considered for external PSII. This would equate to 100 of the 182 incidents over the 4 years reviewed being completed by thematic or external review. Therefore, the following plans have been developed based on anticipation of approx. 20 to 25 individual incident responses each year (supported by the Thematic Reviews and external HSIB reviews).

Having reviewed the incidents requiring a nationally mandated PSII over the last 2 years;

- Never Events,
- Deaths thought more likely than not due to problems in care,
- Deaths of patients detained under the MHA / MCA where death is linked to gaps in care,
- Incidents in NHS screening programes that risk the effectiveness or public confidence in delivery of the programme,

The period of incidents reviewed has identified 14 incidents through 2021/22 (7) and 2022/23 (7) that would have required nationally mandated PSII. These incidents were under the categories of Never Event (7), Deaths thought more likely than not due to problems in care (6) and Death of a patient detained under the MHA (1). The planning will assume a consistent rate of 7 incidents expected to meet national mandated PSII.

Local decisions regarding PSII will be based on those incidents that identify significant failings in expected safety processes such as failure to successfully implement LocSSIPs. It is anticipated that this will lead to a further 3 to 5 PSIIs each year.

The remaining incidents requiring individual investigations (10 to 15) will be anticipated to be suitable for facilitated reflective sessions.

Patient safety incident response plan

Defining our patient safety improvement profile

Following a review of recent incidents requiring further investigation and the Trust incident profile, the safety improvement profile will be based around a specified number of Patient Safety Steering Groups. These groups will be reviewed through the Trust Lessons Learned Forum and amended to support the required safety improvement profile. The initial Patient Safety Steering Groups will include:

- Falls Prevention Steering Group
- Pressure Ulcer Prevention Steering Group
- Infection Prevention Control Steering Group
- Nutrition and Hydration Steering Group
- Deteriorating Patient Steering Group
- Medicines Safety Steering Group
- Mental Health Safety Steering Group
- Radiological Imaging Safety Steering Group
- Management of behaviours that Challenge Steering Group

Whilst steering groups have been identified based on the rates of themes from Serious Incident Investigation findings, some groups have also been identified following other sources of intelligence such as wider incident rates and patient feedback.

Each steering group will complete a thematic review of aligned incidents and maintain a safety improvement plan. The thematic reviews and improvement plan progress will be presented to the Lessons Learned Forum at a frequency agreed in line with the prevalence of aligned incidents. This frequency will be at least annually for all steering groups.

Our patient safety incident response plan: national requirements

Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the Lessons Learned Forum to consider alignment to an existing Safety Improvement Plan.

Death thought more likely than not due to problems in care.	PSII	Create local organisational actions and feed these into the Lessons Learned Forum to consider alignment to an existing Safety Improvement Plan.
Incident meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the Lessons Learned Forum to consider alignment to an existing Safety Improvement Plan.

Our patient safety incident response plan: local focus

As per the Trust PSIRF policy there will be a preference for thematic review and quality improvement planning for incident types that have been seen to reoccur. These have been identified within the patient safety steering groups.

Incidents requiring further individual incident investigation a decision will be agreed through the Patient Safety Response Panel. The decision will be based on a number of factors including;

- Incident Complexity
- Potential for new learning
- Level of risk to future care
- Views of those affected by the Patient Safety Incident

The following table provides a guide for some of the types of incident observed during review of previous years.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Falls	Thematic Review	Review of reoccurring areas for improvement against current patient safety improvement plan
Pressure Ulcers	Thematic Review	Review of reoccurring areas for improvement against current patient safety improvement plan

Failure to identify or respond to a deteriorating patient	Thematic Review	Review of reoccurring areas for improvement against current patient safety improvement plan
Anticoagulation management	Thematic Review	Review of reoccurring areas for improvement against current patient safety improvement plan
Radiological Imaging – discrepancies	Thematic Review	Review of reoccurring areas for improvement against current patient safety improvement plan
Surgical Safety Incidents / failure to utilise LocSSIPS	PSII	Areas for improvement and individual patient safety actions discussed at Lessons Learned Forum to consider need for new patient safety improvement plans
Application of clinical pathways	Facilitated Reflective Sessions	Areas for improvement and individual patient safety actions discussed at Lessons Learned Forum to consider need for new patient safety improvement plans
Errors at the point of handover / Transfer of care	Facilitated Reflective Sessions	Areas for improvement and individual patient safety actions discussed at Lessons Learned Forum to consider need for new patient safety improvement plans
Incidents due to incorrect working diagnosis	Facilitated Reflective Sessions	Areas for improvement and individual patient safety actions discussed at Lessons Learned Forum to consider need for new patient safety improvement plans
Incidents relating to the management of patients Mental Health needs	Thematic Review	Review of reoccurring areas for improvement against current patient safety improvement plan

Incidents leading to Healthcare Associated Infections	Thematic Review	Review of reoccurring areas for improvement against current patient safety improvement plan