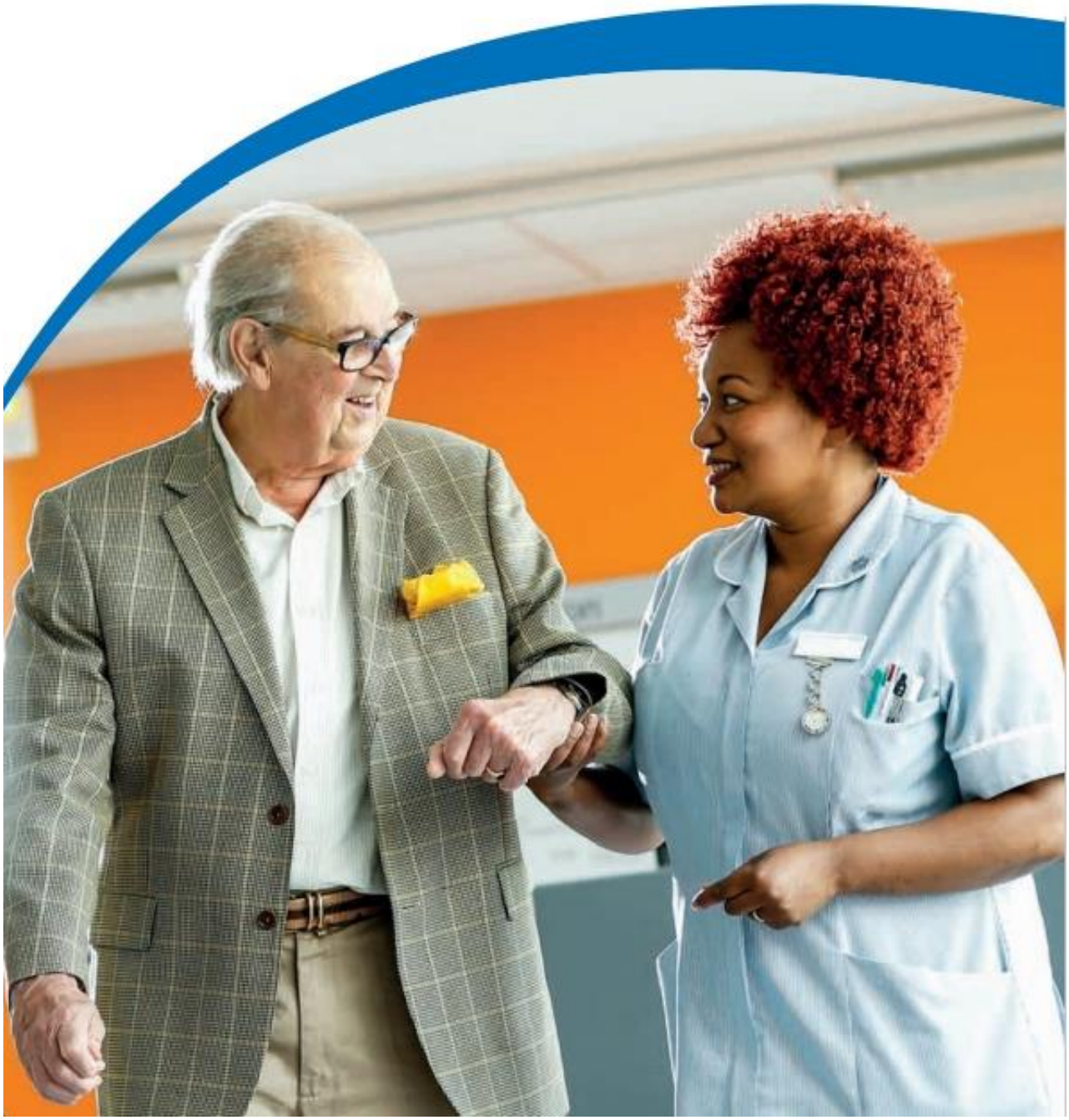
Patient Safety Incident Response Plan (PSIRP)



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Contents

Introduction

This patient safety incident response plan sets out how Maidstone and Tunbridge Wells NHS Trust intends to respond to patient safety incidents over the next 12 to 18 months. The plan is flexible and can be changed in response to new and emerging patient safety issues. Therefore, we will remain vigilant and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

This plan is underpinned by our Trust policies on incident reporting and investigation which are available to all staff via our organisation's intranet page. Each policy has been updated to reflect the new 2023 patient safety incident response framework (PSIRF). NHS England published the new Patient Safety Incident Response Framework (PSIRF) in August 2023, outlining how NHS organisations should respond to patient safety incidents for the purpose of learning and improvement.

At MTW the PSIRF will replace the current Serious Incident Response Framework from 1st April 2024. It represents a significant shift in the way the NHS responds to patient safety incidents, centering on delivering a compassionate service which offers higher levels of collaboration and support to those families and patients affected by adverse incidents related to their care. Key changes also involve also moving away from the traditionally commisioned root cause analysis investigations to a more visual "system" based approach to investigations drawing out earlier learning and improvements with considered and proportionate responses based on the organisations key patient safety issues.

PSIRF is intended to be a major step towards improving safety management across the healthcare system in England and it is envisaged it will greatly support the NHS to embed the key principles of a healthy patient safety culture. It will ensure the NHS and MTW focuses on understanding how incidents happen, rather than apportioning blame on individuals; allowing for more effective learning and improvement, and ultimately making NHS care safer for patients.

PSIRF removes the requirement that all/only incidents meeting the criteria of a 'serious incident' are investigated, allowing for other incidents to be investigated and for learning response resource to focus on areas with the greatest potential for patient safety improvement.

An ongoing thematic analysis plan is in place to determine areas of patient safety priorities for the Trust, produced 6-12 monthly. The local incident response plan detailed within this report was created based on the output of the thematic analysis approach, allowing us to focus our resources on these priority areas.

Alongside the framework, a 'Guide to engaging and involving patients, families and staff following a patient safety incident' has also been published, setting out expectations for how those affected by a patient safety incident should be treated with compassion and involved in any investigation process. To support this MTW will be digitalising our investigation processes, introducing patient contact portals to enhance how patients and their families collaborate with our investigation teams during the invetsigation processes. Alongside this family meeting schedules will be introduced into our invetsigative processes to ensure that we priortise informing and involving them in our investigative processes.

It is our hope that following the implementation of PSIRF, we will see a reduction in reoccuring serious harm and death in our patient safety priority areas over a 2 year period. This will be measured using an average of the last 5 years Serious Incident data (taking into consideration years of extra-ordinary incidents such as Hospital Acquired COVID-19). As part of the transition to PSIRF, we will introduce a digital Patient Safety Incident Investigation (PSII) tool to enable digital analysis of themes and trends using AI analytics. These trends will feed into future areas of focus for our incident response plan.

Our services

Maidstone and Tunbridge Wells NHS Trust (the Trust) is a large acute hospital Trust in the south east of England. The Trust provides a wide range of general hospital services across Maidstone and Tunbridge Wells and their surrounding boroughs. The Trust hosts the Kent Oncology Centre, providing specialist Cancer services to circa 1.9 million people across Kent and East Sussex, the fourth largest oncology service in the country.

The Trust employs over 6,900 full and part-time staff, and operates from three main sites (Maidstone Hospital, Tunbridge Wells Hospital and the Crowborough Birth Centre), as well as managing some services at the Kent and Canterbury Hospital, and outpatient services at several other community locations.

Further information about our organisation can be found on the Trust website

https://www.mtw.nhs.uk/

Defining our patient safety incident profile

The patient safety incident profile was created through engagement with the following stakeholders:

- Our staff – through reviewing and theming our incidents reported on the Trust incident management system and taking feedback from our internal safety culture survey
- Senior leaders within the organisation
- Our patients – through reviewing themes and trends from patient concerns and complaints
- Commissioners/ICB partner organisations – through partnership working with the ICS patient safety and quality leads
- Various governance forums and the Trusts PSIRF implementation working group
- Patient Experience Committee and Healthwatch partners
- Our Patient Safety Partner

The Trust-wide patient safety risks were identified through the following data sources:

- Thematic analysis of three years of Serious Incident data 2019-2022
- Key themes from complaints/PALS/claims/inquests/incidents
- Key themes identified from specialist safety & quality committees (e.g. Sepsis, falls, pressure ulcers)

Defining our patient safety improvement profile

The Trusts' patient safety improvement profile is set out within the Quality Accounts and the Trusts Strategic aims and objectives. They detail the planned improvement and service transformation work that will impact on patient safety across the organisation. Our patient safety aim is to sustain and further enhance robust processes to provide a supportive environment that recognises and reduces avoidable harm.

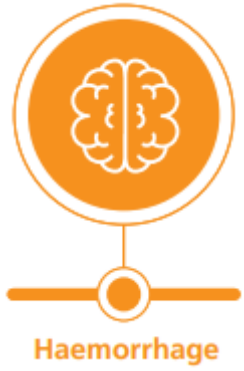
Snapshot of the Patient Safety Aims from the 2022/23 Quality Accounts

Aim	How will we make the improvement	How we will measure our success
 We will improve our Sepsis Pathway	Reviewing and improving our neutropenic sepsis pathway Improving our sepsis safety netting processes in our Emergency Departments by improving our digital sepsis screening processes Redesigning and relaunching our Trust wide sepsis education programme	We will reduce adverse incidents resulting in harm linked to Sepsis management by 90%, this will be monitored via the Deteriorating patient group and workstream
 We will improve upon our management of inpatient falls	Trust Wide Strategic Quality Improvement Workstream One "Improving our patients' environment and our specialist falls reduction equipment" Trust Wide Strategic Quality Improvement Workstream Two "Improving our processes and Improving our workforce" Trust Wide Strategic Quality Improvement Workstream Three "Improving our workforce and understanding our patients evolving needs"	We will reduce our inpatient falls rate by 20% We will monitor compliance with preventative measures via the monthly falls audits

 We will Improve our Maternity performance linked to our antenatal gap and grow measurement processes and improving how we monitor Mothers for signs of high blood pressure	Via dedicated quality improvement projects clinical leaders in maternity will be supported to identify opportunities to improve these specific pathways and explore digitisation of gap and grow	Having no adverse events linked to antenatal “Gap & Grow” measurements & the monitoring of hypertension
 We will improve the safety of our Maternity services by delivering against all of the patient safety recommendations as outlined in the 2022 Ockendon report & the 10 key elements of the National Better Births Plan	We will utilise existing “ward to board” governance and oversight structures to support the leaders in maternity services to track progress, unblock barriers to progress and demonstrate assurance against the key recommendations in the report	Evidence will be collated and uploaded to our Trust Safety Systems which will demonstrate assurance that each required action has been completed

 We will ensure MTW implements all of the recommendations as outlined in the new National Patient Safety Strategy (PSIRF)	Our PSIRF implementation group will continue to deliver on implementing the numerous changes to our systems and processes to ensure we are compliant with the new framework	We will have produced a PSIRF compliant plan (Patient Safety Incident Response Plan) signed off by our Trust Executive Board and our ICS by March 2024

Aim	How will we make the improvement	How we will measure success
 We will implement a new annual Trust wide safety culture measurement system and improve upon our patient safety training	We will launch the 2 new digital systems as part of our existing MTW E-learning (electronic staff learning) system We will work collaboratively with our Organisational Development team and Freedom to Speak Up Guardians to support culture improvement work and measurement	90% of MTWs 6000 staff will have undertaken the basic patient safety module by June 2024 We will relaunch a safety culture measurement diagnostic We will roll out a Just Culture improvement project in collaboration with Organisational Development

 We will improve upon the care of our patients who have nasogastric tube care needs	We will redesign and relaunch our trust wide Nasogastric Tube education plan and competency framework for our staff	We will have launched the new plan and competency framework by August 2022 and by June 2023 60% of registered nurses in high use/acuity departments will have been trained and signed off as competent against the new framework
 We will improve upon our patient outcomes for patients who have suffered an “Intercranial Haemorrhage / bleed” by improving our adherence to national best practice guidance	The clinical teams will be supported to develop an improvement plan which benchmarks this clinical pathway against best practice	Re-audit of the Management of Intercranial Haemorrhage against national best practice guidance results.
	We will work with our informatics leads to review the data available from our new electronic patient record “Sunrise”, to automate 10% of our current mandated national clinical audits We will revamp our existing category set on InPhase and launch a new coding set that will enable greater oversight of themes and trends for our incident data	10% of the current mandatory national clinical audits that are applicable to the Trust (61) will be automated by June 2023 Launch of new category set in April 2024 and ongoing monitoring of the data and themes and trends

We will work with our health informatics team and clinical leaders to automate 10% of our “clinical audit” data collection processes This will release more of our frontline clinical staff’s time		
 We will improve our medicines management safety by launching a new trust wide digital ePMA (electronic prescribing and medicines administration system)	The sunrise / informatics implementation project team will lead on this funded Trust wide transformational change which was launched in December 2022	Transcription Drug Prescribing Errors” will be reduced by 90%

Our patient safety incident response plan: national mandated requirements

The following patient safety incident types must be responded to according to national requirements. (see Appendix A: National event response requirements in the Guide to responding proportionately to patient safety incidents).

Patient safety incident type	Required investigative response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII investigations)	PSII	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process
Child deaths	To refer to the Child Death Overview Panel review. PSII (or other response) may be required alongside the Panel review	If appropriate respond to recommendations as required and feed actions into the quality improvement strategy / MTW strategy deployment process
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). PSII may be required if commissioned by the LeDeR process.	If appropriate respond to recommendations as required and feed actions into the quality improvement strategy / MTW strategy deployment process

Safeguarding incidents	Refer to local authority safeguarding lead, they may commission or refer a case on for: Domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.	If appropriate respond to recommendations as required and feed actions into the quality improvement strategy / MTW strategy deployment process
Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process
Deaths in custody (e.g., police custody, in prison, etc.) where health 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. MTW will fully support these investigations where required to do so.	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process

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)	PSII	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process

Our patient safety incident response plan: nationally mandated maternity requirements

The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of:

Patient safety incident type	Required investigative response	Anticipated improvement route
All term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes*: • Intrapartum stillbirth • Early neonatal death • Potential severe brain injury	To refer to MNSI for external patient safety incident investigation	If appropriate respond to safety recommendations as required and feed actions into the quality improvement strategy / MTW strategy deployment process
Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy.	To refer to MNSI for external patient safety incident investigation	If appropriate respond to safety recommendations as required and feed actions into the quality improvement strategy / MTW strategy deployment process

**N.B. MNSI do not investigate cases where health issues or congenital conditions (something that is present before or at birth) have led to the outcome for the baby. MNSI do not investigate maternal death due to suicide but may expand their investigation criteria for some maternal deaths which do not fit within the table above*

For further information and exclusion criteria please visit: What we investigate (mnsi.org.uk)

Our patient safety incident response plan: Locally agreed approach based on current key safety themes

Patient safety incident type or issue	Required investigative response	Anticipated improvement route
Failure to rescue a deteriorating patient **(Includes significant near misses)** Examples include • Inadequate clinical observations of a deteriorating patient • Inadequate escalation of clinical observations or point of care tests that required immediate treatment • Inadequate response to an escalation of a deteriorating patient	PSII	If appropriate create local organisational actions and feed these into the Deteriorating patient improvement workstream
Mismanagement or delay in the diagnosis and treatment of Sepsis **(Includes significant near misses)**	PSII	If appropriate create local organisational actions and feed these into the Deteriorating patient improvement workstream
Nasogastric tube incidents, specifically, unintentional pneumothorax related to NG tube insertion or aspiration relating to coiled NG tube at the back of the pharynx.	PSII	If appropriate create local organisational actions and feed these into the existing enteral feeding work plans and

		into the Nutrition and Hydration Committee
Diagnostic incidents Examples include • Failure to act appropriately on a diagnostic test result e.g. histology (pathology) test results or imaging results resulting in a significant delay in treatment	After Action Review (AAR)	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process
Patients lost to follow up ***for a period of time that would impact on their treatment / management plans** • Ophthalmology patients lost to follow up resulting in deterioration in vision • Patients lost to follow up on the cancer pathway	After Action Review (AAR)	If appropriate create local organisational actions and feed these into the quality improvement strategy / MTW strategy deployment process
Inpatient falls resulting in fractures or intracranial injury *(*Deaths of patients following inpatient falls will be assessed on a case by case basis in line with the learning from deaths criteria to establish if they require a PSII)*	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement plan for falls reduction
Medication incidents involving • Double wrong dose opioids administered • Significant allergy reaction due to omission or misidentification	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

• Non- intentional duplication of anticoagulant prescribing and administration • Anticoagulation wrong dose administered • Wrong insulin prescribed and administered		
Unexpected new and significant concerning safety event or emerging theme which has potential for future or significant harm	PSII and consider adding to / amending PSIRP for future PSIIs	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Hospital acquired 3 &4 pressure ulcer* *(*Deaths directly relating to a hospital acquired pressure ulcer that meet the learning from deaths criteria will require a PSII)*	AAR with oversight of reviews from Tissue Viability	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions for pressure ulcer prevention
Hospital acquired MRSA* *(*Deaths directly relating to a hospital acquired infection that meet the learning from deaths criteria will require a PSII)*	IPC Rapid review *If red flags from IPC Rapid review commission SWARM huddle*	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Hospital acquired C.diff* *(*Deaths directly relating to a hospital acquired infection that meet the learning from deaths criteria will require a PSII)*	IPC Rapid review *If red flags from IPC Rapid review commission SWARM huddle*	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

	(SWARM within 28 days)	
Hospital acquired venothromboembolism* *(*Deaths directly relating to a hospital acquired VTE that meet the learning from deaths criteria will require a PSII)*	AAR with oversight of reviews from Lead Consultant/ Nurse for VTE	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
New or evolving trend concerning medication incidents or administration of blood products	Deep dive thematic review to be presented at Trust Quality Deep Dive	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Significant emerging risks identified as a result of the use of our digital systems	Multidisciplinary team (MDT) review with key informatics and clinical leads	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Information governance or data protection breach ICO notifiable	SWARM huddle	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Safety incident linked to significant adverse media for the organisation	SWARM huddle	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

Safety II - Learning from excellence – events demonstrating a significant potential for organisational learning	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

Our patient safety incident response plan: Locally agreed approach based on current key maternity safety themes

Patient safety incident type or issue	Planned response	Anticipated improvement route
Stillbirth not meeting the MNSI criteria *excludes expected or unavoidable death in utero	PSII	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Failure to rescue a deteriorating Mother or New-born infant *Near miss or serious harm • Includes failure to respond to abnormal foetal heart rate	PSII	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

Near miss swab management incident / retained instrument incident that demonstrates a significant risk	After Action Review (AAR) (*Incidents meeting the Never Event criteria will require a full PSII)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Poor management of 3rd or 4th degree vaginal tears	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Poor management of Postpartum Haemorrhage >1500mls (failure to recognise the risk, or manage appropriately)	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Failure in the Gap & Grow Measurement processes impacting plan of care **(Failure to monitor foetal growth correctly)**	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Dropped New-born *clinical staff or family	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

Inappropriate discharge from Maternity Services that should have triggered an admission	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Shoulder Dystocia **(failure to recognise the risk, or manage appropriately)**	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Skull fractures and/or intracranial injury related to instrumental deliveries	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Unexpected Maternal admission to ICU following delivery	After Action Review (AAR)	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions
Unexpected admission to the neonatal unit (full term babies)	Follow ATTAIN process and MDT Review	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

Unexpected admission to the neonatal unit (premature babies)	MDT Review	If appropriate create local organisational actions and consider additions to ongoing Trust-wide improvement actions

Appendices

Appendix 1 – Patient Safety Incident Response Policy	TBC – policy in draft
Appendix 2 – PSIRF Learning Response Toolkit	NHS England » Patient safety learning response toolkit