Patient safety incident response plan

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Introduction

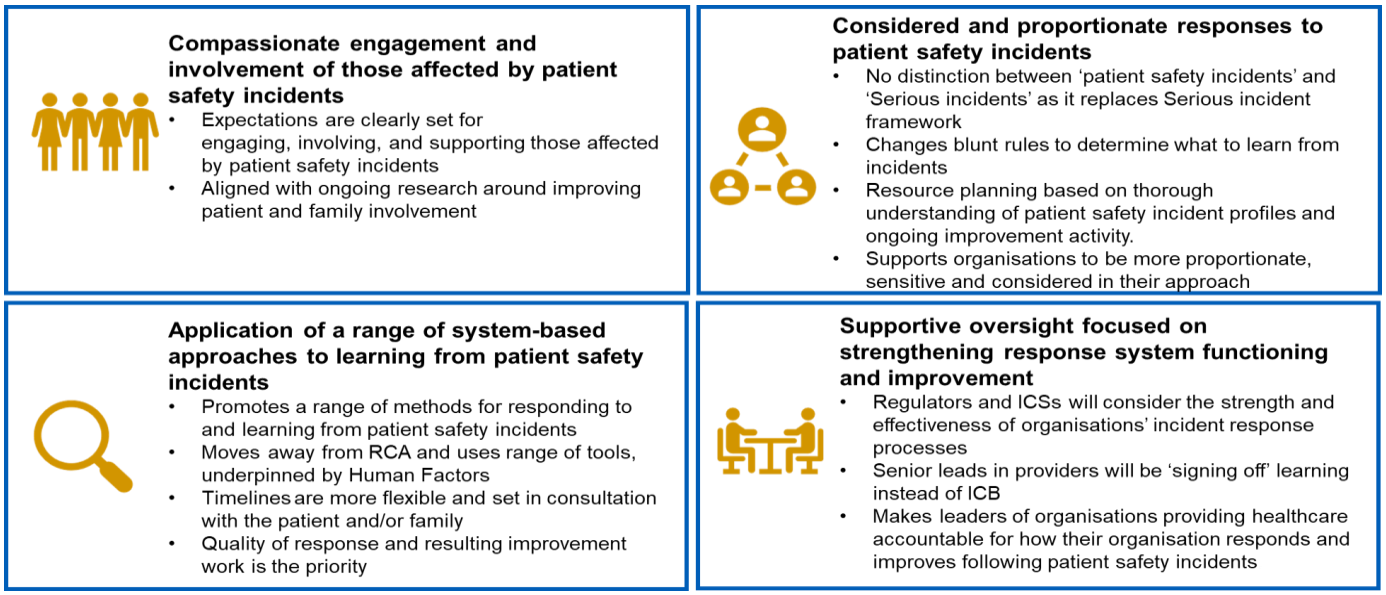
We are committed to delivering effective, positively experienced, and safe care always. We are proud that we do achieve this most of the time. When things haven't happened as we expected, we recognise the need to understand this and make changes based on what we learn. We also know that to make sure our learning resulting in lasting improvements, we must use the right approach and involve those affected meaningfully as we do so. In addition, we need to develop ways to measure how we have improved safety and the experience of our services from the perspectives of those who receive and deliver them, in response to our learning.

This Patient Safety Incident Response Plan sets out how the **Countess of Chester Hospital NHS Foundation Trust** intends to respond to patient safety incidents over a period of 12 months from implementation. All services are within the scope of this plan.

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.

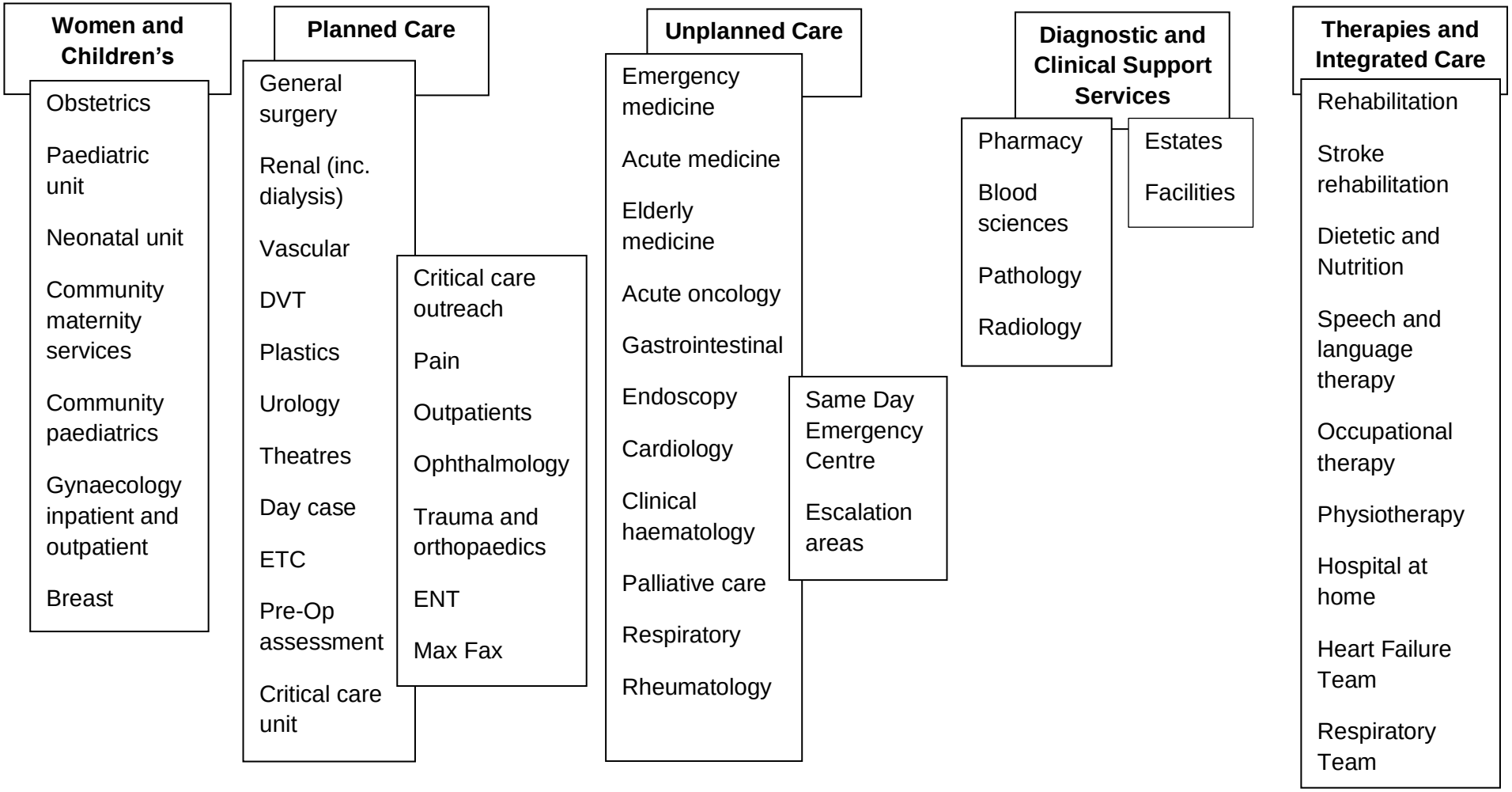
As described within the Trust Patient Safety Incident Response Policy document (to be read in conjunction with this document), our Patient Safety Incident Response Plan is underpinned by our commitment to deliver the four key aims of the Patient Safety Incident Response Framework (PSIRF) in how we respond to patient safety incidents and our approach to patient safety overall.

PSIRF Aims



Our services

The diverse range of services delivered across the Trust are within the scope of this plan.



Alongside and working as an integrated system with our divisional services, sit Trust-wide corporate services that support a range of functions that relate to patient safety and quality improvement work:

- Risk and safety team
- Infection Control and Prevention team
- Quality team
- Continuous Improvement team
- Safeguarding and Complex Care team
- Complaints and Patient Advice and Liaison Service (PALS) teams
- Clinical Audit Team
- Clinical and Medical Education services

Welsh Interface

Many Welsh patients and their families use our hospital services. We are committed to continued close working with Welsh system partners to understand the recognised variations in incident management processes so this can be reflected in updated procedural guidance for our staff.

Defining our patient safety incident profile

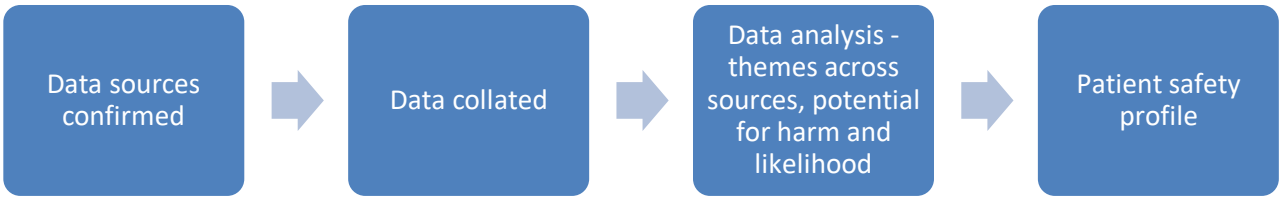
To develop a plan that reflects what happens in the Trust, we needed to define our patient safety incident profile. Our profile consists of the key patient safety issues or concerns that we identified through our data.

Learning from PSIRF early adopter providers and NHS England PSIRF guidance has also been used to assist the trust in the process of identifying and agreeing the patient safety areas most relevant to the trust improvement priorities at this time.

These areas will inform how the trust will direct resources to respond to patient safety incidents and improvement work, as described within this patient safety incident response plan. In doing this we ensure that we are developing a way of working that relates and is informed by the needs and perspectives of our patients, their families or friends and our staff.

It has been recognised through this work that there is ongoing action required to assure data quality and consistency within our DATIX system, a position has therefore been used taken from data already used to report internally and externally.

The sequential process we have taken to establish our patient safety incident profile is set out below:



Further factors that informed the identification of key patient safety areas are described below. This step was relevant to help focus on how we will respond to patient safety incidents proportionately, to spend the most time possible on learning and improving. This is in comparison to how we have worked in the past, where we would undertake several investigations over a period of months, for the same types of incidents, that resulted in the same consistent learning points. We are working to be to able balance how resources are used to deliver high quality learning responses and improvements across all our services.

Factors to further consider and inform patient safety profile

A. Potential for harm:

I. People

a. Physical
b. Psychological
c. Loss of trust (patients, family, carers)

II. Service delivery

a. Impact on quality
b. Delivery of services
c. Impact on capacity

III. Public confidence

a. Political attention and media coverage

B. Likelihood of occurrence:

I. Persistence of risk
II. Frequency
III. Potential to escalate

Stakeholder engagement

While developing our safety profile we considered data from a range of sources to understand where there was correlation between themes and areas for focus.

- **Staff** –
  - DATIX incident reports (Trust incident reporting system)

    - Incident response investigation resource analysis to understand how this is done currently and resources required, as well as challenges
    - Feedback obtained through focus groups delivered January to April 2023
    - Feedback obtained through 1 to 1 sessions undertaken with range of staff members from different professional backgrounds and services (e.g., Blood sciences, radiology, pathology, infection prevention and control, pharmacy, wards, critical care, and corporate services). This provided insight and 'soft intelligence' about patient safety issues and concerns
    - Staff Survey Results November 2022
- **Service users, carers, and family** – through a high-level thematic review of complaints and PALS concerns data
- **Corporate services engagement** – to understand current improvement workstreams, to review metrics design, quality improvement data, safeguarding processes.
- **PSRIF Working Group** – Convened December 2022 to oversee and steer PSIRF preparation and development. Membership incorporates divisional and corporate leads.

Data Sources

- DATIX incident themes April 2018 to November 2022
- Complaint and PALS concerns category themes April 2018 to November 2022 extracted from DATIX
- Report obtained from trust Legal Services Regulation 28 reports – To prevent future deaths
- Electronically held Learning from Deaths themes December 2017 to January 2021 (Structured Judgement Reviews)
- DATIX held - Never Events April 2018 to November 2022
- NHS Resolution Clinical Claims score card
- Staff Survey high level themes 2022
- Freedom to Speak Up Reports 2018-2023

Patient Safety Incidents

A total of 31,299 incidents were reported between April 2018 and November 2022. This period was chosen to align with the trust PSIRF preparation workstream and would be re sampled ahead of reviewing this plan in 12 months' time.

Analysis of incident categories reported in DATIX shows the top 10 types of recurring incidents reported over the period reviewed (Table 1) which equate to 30% of all incidents. These are incidents where there is evidence of **persistent** and **recurring** risk over each year, although variation is recognised.

Table 1. Top 10 reported incidents

Incident Category
1.Slip, Trip, Fall (In-Patient)
2.Skin Integrity
3.Medication
4.Infection control
5.Treatment
6.Staffing
7.Obstetric
8.Unexpected events
9.Bed management
10.Equipment

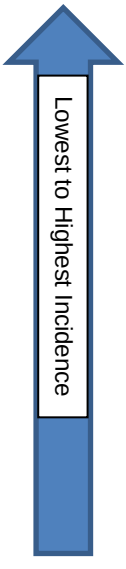
The harm associated with each type of incident varies within each category (Table 2), it is noted that variation in harm associated with infection control correlates in part to a spike due to COVID 19 in 2020/21. We reviewed data across a broad timescale so that the risk of COVID 19 impact influencing data would be minimised.

Table 2 below shows a comparison of incidents recurring in high numbers but with lower levels of harm, versus those showing lower numbers of incidents but more significant consequences arising. **25% of incidents were associated with medium to longer term harm, including death (moderate to catastrophic), 75% were associated with no or low harm**. It is recognised that incidents occurring with no or low harm include 'near misses' and show **potential for greater to harm to arise** if incidents of that nature continue to recur.

This reflects a positive culture of reporting incidents without significant harm and provides an opportunity to learn from them using a more thematic approach.

Table 2. Harm associated with incidents

None (no harm caused - Near Miss)	Low (minimal harm caused)	Moderate (short term harm caused)	Severe (permanent or long-term harm caused)	Catastrophic (Death Caused by the Patient Safety Incident)
Medication	Slip, Trip, Fall (In-Patient)	Skin Integrity	Skin Integrity	Infection control
Slip, Trip, Fall (In-Patient)	Skin Integrity	Infection control	Treatment	Unexpected events
Staffing	Medication	Obstetric	Slip, Trip, Fall (In-Patient)	Treatment
Treatment	Treatment	Slip, Trip, Fall (In-Patient)	Obstetric	Slip, Trip, Fall (In-Patient)
Bed management	Infection control	Treatment	Unexpected events	Obstetric
Equipment	Unexpected events	Medication	Infection control	Staffing



Obstetric	Staffing	Unexpected events	Bed management	Equipment
Unexpected events	Obstetric	Staffing	Medication	Skin Integrity
Infection control	Equipment	Equipment	Staffing	Bed management
Skin Integrity	Bed management	Bed management	Equipment	Medication

Each incident type can be further understood through sub categorisation. The incident subcategories for the above incidents have been further scrutinised to understand in more detail the specific nature, frequency and level of harm shown in the data. This analysis has shaped the trust patient safety incident profile set out at the end of this section and informed the rationale presented about why each incident type is reflected within this plan.

Complaint and PALS themes

Complaints and concerns are recognised indicators of quality and safety issues communicated by those who use and experience our services. The top 7 themes arising from a combination of complaints and concerns data (table 3) have been reviewed and correlate with themes arising from patient safety incidents, whilst also giving further insight into how care is experienced.

Table 3. Complaint and Concern themes

Complaint and Concern Theme
1.Clinical Treatment
2.Delayed Treatment
3.Communication
4.Attitude
5.General Patient Care
6.Other
7. Safety

Regulation 28 reports – To prevent future deaths

During the period reviewed, one report was received by the Trust from HM Coroner. This highlighted concerns in relation to radiology services reporting and diagnostic decision-making processes within the emergency department.

Learning from deaths – themes

All NHS Trusts are mandated to undertake a review of care when a person has died and there are concerns about care which warrant further review by a doctor, using a standardised method (e.g., Structured Judgement Review). Concerns may arise from the Medical Examiner (external person who reviews care of someone who has died),

family, or staff. Equally, concerning trends may be seen in death rates linked to specific conditions that warrant further scrutiny. Analysis of electronically held Structured Judgement Reviews between December 2017 and January 2021 (Table 4), has looked at the themes associated with each review and harm associated with each theme. The correlation between these areas and those highlighted within the recurring incident categories and complaints is recognised.

Table 4. Learning from Deaths

Care concern
Assessment
Intervention
Diagnosis
Medication
IV fluids
Electrolytes
Oxygen
Treatment
Management
Infection management
Operative
Invasive procedures
Clinical monitoring
Cardiac arrest
Respiratory arrest
Other

Never Events

9 Never Events have been reported during the period, through their thematic reviewed it is recognised that they align to findings set out within learning from deaths data in relation to recurring incidents associated with invasive procedures and their volume. This has also correlated to recurring incidents, when subcategories were scrutinised.

Staff Survey

3 Priority areas arising from 2022 Staff Survey:

- Grow the focus on staff well-being
- Work to ensure that staff feel comfortable raising concerns about unsafe clinical practice by improving communication on the actions taken by the organisation.
- Look at ways for staff to show their appreciation to each other with an improved reward and recognition scheme.

Claims scorecard NHS Resolution

Data is extracted from NHS Resolution's (NHSR) claims management system, for the trust claims scorecard for the period 1.4.12 to 31.3.22. The scorecard is a database of all claims made against the trust, over a 10 year period. The scorecard provides information of open and closed negligence claims, brief description of the clinical event and the associated compensation and legal costs – both estimated (open claims) and actual (closed or settled claims). There are two scorecards – clinical and non-clinical negligence claims. The information for clinical claims are set out by speciality and can be manipulated by the trust to understand the relationship between incidents and claims – highlighting potential quick solutions in high volume claims. The scorecard is not a live document and therefore information is updated annually by NHSR.

Patient Safety Incident Profile

Category of incident	Description	Rationale
Slip, Trip, Fall (In-Patient)	Falls occurring witnessed or otherwise, with equipment associated in some cases.	Highest recurring incident type with harm arising at all levels. Recognised impact on flow and mortality/morbidity. Over 50% of incidents associated with significant harm.
Skin Integrity	Newly acquired stage 1-4 pressure ulcers, unstageable wounds and deep tissue injuries which have occurred whilst in hospital.	Second highest recurring incident type with harm at all levels. Over 50% of incidents associated with significant harm.
Medication	Prescription, administration pharmacy dispensing errors Drugs not given Monitoring issues Controlled drugs error Electronic prescribing error TTO issues Medicines storage	Third highest recurring incident type with harm across all levels
Infection control	Reportable bacteraemia infections. Hospital onset COVID 19. Deaths related	Fourth highest recurring incident type. Harm

	to CDIFF. Outbreaks and closures of wards/bays within wards.	associated known to be across all levels.
Treatment	Treatment and appointment delays, sub optimal or in appropriate treatment. Delays in medical review. Incorrect preparations for theatre. IV infusion complications. Referral back to theatre within 10 days of surgery. Breach of cancer referral to treatment pathways.	Fifth highest recurring incident type. Over 50% of incidents associated with significant harm.
Staffing	Staff availability and impact on ability to deliver specific tasks, reported lack of training, breach of working hours, movement of staff to address gaps, attitudinal reporting	Sixth highest recurring theme. Significant reporting associated with no harm/near misses although evidence across all harm levels.
Obstetric	Post-partum haemorrhage, tears, shoulder dystocia, term admissions to neonatal unit, unplanned maternal transfers to theatre, returning to theatre, fetal blood samples of less than 7.19. Post-natal readmission for mother, birth injury, unplanned hysterectomy, Apgar score at birth below 3, intrauterine death.	Seventh highest recurring incident area with associated high-cost claims and impact on public perception of the organisation. Proportionally high numbers of incidents in moderate to severe categories. Evidence across all harm levels. Over 50% of incidents associated with significant harm.
Unexpected events	Inclusive of unexpected deaths, collapse, deterioration in condition and complications during operation or procedure	Eighth highest recurrent incident type. Occurring proportionately higher in severe and catastrophic harm levels.
Bed management	Admission/transfer quality, delays in flow, bed availability (ITU/HDU/neonatal/surgical), appropriateness of patient placement	Ninth highest occurring incident type with recognised links to system functions. Occurring most in no harm category but present across all categories of harm
Diagnosis	Delayed, missed or incorrect diagnosis	Tenth highest occurring incident type with links to system functions and processes as well as care pathways. Occurring across all harm areas.

Defining our patient safety improvement profile

As an organisation we are committed to delivering high quality health care through a culture of continuous improvement, where there are visible lines drawn between learning we have found, and actions taken. We have seven workstreams that align to trust wide priorities developed through clinical engagement. They correlate to the Trust safety profile developed through this work also.

Current improvement and service transformation work

Our current improvement workstreams are presented in the table below, ranging from regional/national, trust-wide to speciality specific ones.

	Improvement workstream	Focus
Regional/National	**Clostridium Difficile Collaborative Improvement Workstream**	Regionally coordinated looking at RCA processes, incident management processes and common themes. Considering how approach will change in line with PSIRF
	Critical care workforce development	Regionally led through the clinical network with focus on upskilling, development, and retention of staff.
	Falls Strategic Group	Place-based group developing joint assessment tools, data and system learning
Trust wide	**Inpatient Falls Prevention Programme**	Undertaking stock take of data, best practice initiatives Designing improvement workplan and streams
	Inpatient Pressure Ulcer Prevention Programme	Undertaking stock take of data, best practice initiatives. Designing improvement workplan and streams with focus on: 1. ED improvement 2. Assurance and compliance 3. Equipment 4. Cerner 5. Datix/validation/data

	Pressure Ulcer Review Meeting	Weekly review of pressure ulcer incidents and learning arising for Level 3 and 4 wounds
	Medicines Safety	Undertaking stock take of data, best practice initiatives. Designing improvement workplan and streams
	Deteriorating patient group	Undertaking stock take of data, best practice initiatives since inception in 2021. Designing improvement workplan and streams
	Emergency Department Improvement Project	Undertaking stock take of data, best practice initiatives. Designing improvement workplan and streams
	Acute Kidney Injury(AKI)	Undertaking stock take of data, best practice initiatives from group since 2022. Designing improvement workplan and streams, including maintaining regional reporting of data.
	Sepsis	Undertaking stock take of data, best practice initiatives since group inception 2021. Designing improvement workplan and streams, including maintaining regional reporting of data
	Trust-wide Patient Experience Operational Group	Strategic planning, oversight, and leadership of workstreams driving improvement in patient engagement and experience
	Local Safety Standards for Invasive Procedures (LocSSIPs)	Development of checklists, quality assurance and improvement oversight for 12 month period to support embedding in practice
Speciality Level	**Women and Children's divisional system integration group**	Scoping and improving whole system pathways, resources, and services in response to updated national guidance
	Women and Children's divisional quality and safety group	Clinical governance and continuous improvement
	Women and Children's divisional workforce group	Retention, CPD, communication and engagement
	Women and Children's divisional digital group	Implementation of digital clinical services above EPR. Digital communication tools.
	Women and Children's divisional patient experience group	Strategic approach to expanding how voice of patients, families and carers is heard and how partnership working is strengthened
	Neonatal Term Admissions to Neonatal Unit	MDT meeting that reviews all cases where term (>37 weeks gestation) admission have occurred

		to identify learning and improvement actions required

Planned patient safety improvement workstreams 2023/2024

To complement and further inform the existing improvement workstreams, the following discrete patient safety improvement workstreams are planned over the next 12 months. They are small to allow adequate time and resources to deliver.

Improvement workstream	Aim
Quality improvement and learning from patient safety incidents	Strengthen and/or develop systems, processes and tools through which learning from patient safety incident responses can be mapped and measured for the purpose of: 1. Informing existing improvement workstreams 2. Develop mechanism to identify emerging priority areas for improvement planning

Our patient safety incident response plan: national requirements

The choice of learning response is informed by what we want to get out of the learning activity. This ensures we are meaningful and proportionate in how we respond. We will need to work with patients, families and staff to agree how we will respond.

The trust Patient Safety Incident Response Policy document outlines how we will undertake Being Open and Duty of Candour. This is as important for our staff, as it is for our patients and their families.

There are three objectives we have considered when developing this plan (Appendix 1). Depending on the nature of the incident and the elements set out below, there are a range of learning responses available that give us greater flexibility in how we can respond. These are set out within our local plan later in this document.

This said, in line with NHSE PSIRF guidance we are required undertake specific patient safety incident learning responses for a nationally mandated group of incident types. This ensures that there is consistency in the approach to understanding patient safety incidents across all providers. These are set out within the table below:

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	Patient safety incident investigation (PSII)	Create local organisational learning actions and feed these into the quality improvement strategy Feed learning and where necessary actions into the relevant quality improvement workstream, including LocSSIPs group
Incident meets the learning from deaths criteria (Death thought more likely than not due to problems in care)	Patient safety incident investigation (PSII)	Create local organisational learning actions and feed these into the quality improvement strategy Feed learning and where necessary actions into the relevant quality improvement workstream
Incidents meeting Each Baby Counts criteria • Early neonatal deaths • Intrapartum still births • Severe brain injury in babies born at 37 or more weeks • Maternal death	72 Hour Review Referred to Healthcare Safety Investigation Branch (HSIB) for independent patient safety incident investigation and/or Perinatal Mortality Review Tool (PMRT) (baby deaths up to 28 days post birth)	Respond to recommendations as required and develop range of learning actions Feed learning and where necessary actions into the relevant quality improvement workstream
Deaths of persons with learning disabilities	72 Hour Review	Respond to recommendations as

	Refer for Learning Disability Mortality Review (LeDeR) (A locally led PSII/other response may be required alongside panel review and this will be subject to liaison with the LeDeR programme)	required and develop range of learning actions Feed learning and where necessary actions into the relevant quality improvement workstream
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where incidents meet the learning from deaths criteria	Patient safety incident investigation (PSII) led by the organisation within which the incident occurred	Respond to recommendations as required and develop range of learning actions Feed learning and where necessary actions into the relevant quality improvement workstream
Child deaths	Refer for Child Death Overview Panel review 72 Hour Review (A locally led PSII/other response may be required alongside panel review and this will be subject to liaison with the panel) Review case within paediatric mortality and morbidity (M&M) meeting	Respond to recommendations as required and develop range of learning actions Feed learning and where necessary actions into Paediatric M&M Meeting and Child Death Overview Panel review process
Safeguarding incidents in which: Babies, children, or young people are on a child protection plan or a victim	Refer to local authority safeguarding lead Contribute towards: • Domestic independent inquiries	Respond to recommendations as required and develop range of learning actions

of wilful neglect or domestic violence/abuse Adults over 18 years in receipt of care and support needs from their local authority Incident relates to FGM, PREVENT (radicalisation), modern slavery, human trafficking, domestic abuse/violence	• Joint targeted area inspections • Child safeguarding practice reviews • Domestic homicide reviews • Any other safeguarding reviews as required by the local safeguarding partnership board (children and adults)	Feed learning and where necessary actions into the relevant quality improvement workstream
Incidents in NHS Screening Programmes Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)	Report made by service to regional Screening Quality Assurance Service and Screen and immunisation team to advise of incident Patient safety incident investigation (PSII) led by the organisation within which the incident occurred	Respond to external recommendations arising as required and develop range of learning actions Create local organisational learning actions Feed learning and where necessary actions into the relevant quality improvement workstream

Our patient safety incident response plan: local focus

Our local focus response plan considers existing improvement workstreams and types of incidents where past learning is not indicating new learning and there are improvement workstreams in place, it also recognises areas where there has been local soft intelligence around trends in incidents.

In line with the aims of nationally mandated responses, the learning response is undertaken for the sole basis of learning to improve and not to apportion blame or to support any other process which may arise because of a patient safety incident. We are working to embed learning responses that happen within teams so that learning can be owned and delivered at the service level wherever possible.

Tools developed with consistent Key Lines of Enquiry (KLOEs) means that we can use information obtained through a learning response to identify themes and trends in learning (why things may have gone wrong), so we can take a more systematic approach to how we improve our services.

Patient safety incident type or issue	Planned response	Anticipated improvement route
All incidents regardless of harm level	Initial case review at service level is undertaken to ensure everyone's safety and to establish facts. The output is solely recorded within DATIX and planned further response type (informed by this response plan) is documented in line with this guidance, if a further response is relevant. Duty of Candour verbal and written steps taken for incidents resulting in moderate or greater harm.	Immediate actions identified and implemented to manage incident and address any immediate learning actions identified
Breach of cancer waiting times (31 or 62 or 104 days) with harm	72 hour review led by specialty within which the breach occurred led by operations manager	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases to triangulate with complaints and claims with speciality representatives across the pathways e.g., clinical pathology, diagnostics Feed learning and trends into Cancer Steering Group

Infection prevention and control incidents with associated harm including Healthcare acquired infections (HCAI) but excluding those in scope for nationally defined responses e.g.: Clostridium Difficile, MRSA Bacteraemia, Vancomycin Resistant Enterococci Bacteraemia, COVID 19 (probable/definite hospital acquired)	72 hour review led by the service within which the incident occurred with input from IPC (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases to triangulate with complaints and claims Feed actions and thematic review recommendations into the IPC quality improvement strategy and ICS led improvement workstream
Hemovigilance Serious adverse events - any untoward occurrence regardless of the level of harm, that is associated with **patient identification** in relation to blood or blood components that might or could potentially lead to death or life threatening, disabling, or incapacitating conditions for patients or which results in or prolongs hospitalisation or morbidity	72 Hour Review led by service within which incident occurred, with transfusion team as subject matter experts - (Following consistent KLOES linked to standards/guidelines and Trust improvement actions) Human factors questionnaire completed by those involved and incorporated into findings of the 72 Hour Review Referral to SHOT Referral to MHRA	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases Feed actions and thematic review recommendations into trust-wide improvement workstreams linked to learning areas identified
Hemovigilance Serious adverse events – any untoward occurrence associated **with the collection, testing, processes, storage and distribution of blood or blood components** that might or could potentially	72 Hour Review led by service within which incident occurred, with transfusion team as subject matter experts - (Following consistent KLOES linked to standards/guidelines and	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases Feed actions and thematic review recommendations

lead to death or life threatening, disabling, or incapacitating conditions for patients or which results in or prolongs hospitalisation or morbidity	Trust improvement actions) Human factors questionnaire completed by those involved and incorporated into findings of the 72 Hour Review Referral to SHOT Referral to MHRA	into trust-wide improvement workstreams linked to learning areas identified
Hemovigilance Serious adverse reactions -means an unintended response in a patient that is associated with the transfusion of blood or blood components that is fatal, life threatening, disabling, or incapacitating or which results in or prolongs hospitalisation or morbidity	72 Hour Review led by service within which incident occurred, with transfusion team as subject matter experts - (Following consistent KLOES linked to standards/guidelines and Trust improvement actions) Human factors questionnaire completed by those involved and incorporated into findings of the 72 Hour Review Referral to SHOT Referral to MHRA	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases Feed actions and thematic review recommendations into trust-wide improvement workstreams linked to learning areas identified
Exposure to non-ionising radiation to the wrong patient/wrong body part	Referred to Radiation Protection Advisor to determine harm If no/low harm – DATIX incident report case review is completed to fact find and establish improvement actions OR	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases to triangulate with complaints and claims Feed actions and thematic review recommendations into trust-wide improvement workstreams

	If Moderate or greater harm – Radiation Incident Investigation Document	
Slip, trip and fall leading to moderate or greater harm, excluding incidents in scope for nationally defined responses.	Falls Rapid Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases to triangulate with complaints and claims Feed actions into the falls quality improvement strategy group
Slip, trip, and fall resulting in no/low harm	Falls Rapid Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases to triangulate with complaints and claims Feed actions and learning into the falls quality improvement strategy group
Medication incidents with moderate or greater harm (Excluding those in scope for nationally defined responses)	72 Hour Medication Incident Learning Review led by team within area that the incident occurred, Pharmacy local link to input into review but not lead (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases/ sub-category of no/low/ near miss incidents Feed learning into the Medicines Safety quality improvement strategy group
Treatment - excluding those in scope for nationally defined responses and cancer	MDT Review led by team within area that the incident occurred	Create and implement local immediate and

pathways or screening incidents e.g. Treatment and appointment delays, sub optimal or in appropriate treatment. Delays in medical review. Incorrect preparations for theatre. IV infusion complications. Referral back to theatre within 10 days of surgery.	(Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	organisational learning actions Quarterly thematic review of 20 cases/ sub-category of no/low/ near miss incidents Feed learning and actions into the quality improvement strategy led by deteriorating patient group or most appropriate improvement workstream based on learning
Invasive Procedures incidents irrespective of the level of harm	72 Hour Incident Learning Review led by team within area that the incident occurred (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases to triangulate with complaints and claims Feed learning into the LocSSIPs Group
Diagnosis - excluding those in scope for nationally defined responses and cancer pathways or screening incidents	MDT Review	Create and implement local immediate and organisational learning actions Quarterly thematic review of 20 cases to triangulate with complaints and claims Feed learning and actions into the quality improvement strategy led by deteriorating patient group
Skin integrity – Category 1 to 2 New pressure ulcers/unstageable wounds and deep tissue injuries/skin tears	Reviewed and managed by local manager with oversight from Matron (Following consistent KLOES linked to standards/guidelines and	Create and implement local immediate and organisational learning actions at manager level using template Feed organisational learning actions into the inpatient

	Trust improvement actions)	pressure ulcer improvement group
Skin integrity – Category 3 to 4 New pressure ulcers/unstageable wounds and deep tissue injuries/skin tears	72 Hour Pressure Ulcer Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate and organisational learning actions Review learning at weekly pressure ulcer review meeting to share Trust-wide through group membership
Safeguarding incidents – incidents where safeguarding policy or processes have not been followed	72 Hour Review led by service within which incident occurred – (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate and organisational learning actions Feed organisational learning actions into the Trust-wide Safeguarding Steering Group meeting
Safeguarding incidents – incidents where mental health act or mental capacity act process has not been followed	72 Hour Review led by service within which incident occurred – (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate and organisational learning actions Feed organisational learning actions into the Trust-wide Safeguarding Steering Group meeting
Unexpected events with significant potential learning and/or harm/risk arising. These are incidents that are not already described within the categories set out in this plan	PSII	Create and implement local immediate and organisational learning actions Feed organisational learning actions into the appropriate improvement workstream group
Bed management	72 Hour Review (Following consistent KLOES linked to standards/guidelines and	Create and implement local immediate organisational learning actions

	Trust improvement actions)	Feed organisational learning actions into the appropriate improvement workstream group
Staffing	Initial case review at service level validated by division, output recorded within DATIX report with recommended further response type agreed if necessary	Create and implement local immediate organisational learning actions Feed organisational learning actions into the appropriate improvement workstream group
Equipment	Initial case review at service level validated by division, output recorded within DATIX report with recommended further response type agreed if necessary	Create and implement local immediate organisational learning actions Feed organisational learning actions into the appropriate improvement workstream group
Ophthalmology incidents regardless of harm level	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate and organisational learning actions Feed actions into locality improvement workstream
Information governance	Where incident reported at service level - Initial case review at service level and record outcome within DATIX Or Where IG team informed of breach - Initial case review IG team level and DPO if necessary and record outcome within DATIX/IG casefiles to maintain confidentiality	Create and implement local immediate organisational learning actions Feed organisational learning actions into the appropriate improvement workstream group including: Face to face IG training Staff bulletin communications Preceptorship leads feedback

	Notify Information Commissioner (ICO) of breach	

Obstetric, Neonatal and Paediatric incidents

Incidents that do not require HSIB referral, PMRT or meet other nationally mandated response guidance, require an agreed response and learning action.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Post-partum haemorrhage >500mls and <1500mls	Initial case review at service level validated by division, output recorded within DATIX report with recommended further response type agreed if necessary	Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Communicate learning via newsletter where appropriate
Post-partum haemorrhage >1500mls and <3000mls	72 Hour PPH Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Quarterly thematic review of 20 cases Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Communicate learning via newsletter where appropriate Feed local and organisational learning actions into the appropriate improvement workstream group

Post-partum haemorrhage >3000mls	72 Hour PPH Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Communicate learning via newsletter where appropriate Feed local and organisational learning actions into the appropriate improvement workstream group
Post-partum haemorrhage leading to operative intervention (excluding emergency hysterectomy)	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Communicate learning via newsletter where appropriate Feed local and organisational learning actions into the appropriate improvement workstream group
Post-partum haemorrhage regardless of intervention that has led to need for transfer to ITU	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Feed local and organisational learning actions into the appropriate improvement workstream group
Post-partum haemorrhage leading to further return to theatre	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Feed local and organisational learning actions into the appropriate improvement workstream group
Post-partum haemorrhage leading to	PSII	Create and implement local immediate learning actions

unplanned hysterectomy		Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Feed local and organisational learning actions into the appropriate improvement workstream group
Admission to PICU for a child	Structured Case Presentation at Paediatric Mortality and Morbidity Meeting	Create and implement local immediate learning actions Case reviewed at Paediatric Mortality and Morbidity meeting, learning confirmed, themes/trends identified, improvement priorities set as appropriate
Admission to Neonatal Unit >37 weeks gestation (Term admissions)	Structured Case Presentation at Term admission meeting based on clinician case review	Create and implement local immediate learning actions Case reviewed at Term Admission meeting, learning confirmed, themes/trends identified, improvement priorities set as appropriate Feed organisational learning actions into the appropriate improvement workstream group
3rd and 4th degree tear	72 Hour review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Feed organisational learning actions into the appropriate improvement workstream group
Shoulder dystocia	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group

		Feed organisational learning actions into the appropriate improvement workstream group
Unplanned Maternal transfer to ITU/HDU	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Feed organisational learning actions into the appropriate improvement workstream group
Return to theatre	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Feed organisational learning actions into the appropriate improvement workstream group
Postnatal re-admission mother	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Feed organisational learning actions into the appropriate improvement workstream group
Birth Injury / iatrogenic injury to baby	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Feed organisational learning actions into the appropriate improvement workstream group
Unplanned hysterectomy	PSII	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group

		Feed organisational learning actions into the appropriate improvement workstream group
Paediatric sepsis	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Feed organisational learning actions into the appropriate improvement workstream group
Apgar score <3 at 5 minutes and/or referred for total body cooling	72 Hour Review (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Create and implement local immediate learning actions Feed organisational learning actions into the appropriate improvement workstream group Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group
Referred for total body cooling	HSIB referral 72 Review - (Following consistent KLOES linked to standards/guidelines and Trust improvement actions)	Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group Create and implement local immediate learning actions Feed organisational learning actions into the appropriate improvement workstream group
Intrauterine death	MDT Review Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group	Create and implement local immediate learning actions Feed organisational learning actions into the appropriate improvement workstream group Incident outcomes and learning reviewed weekly at Multidisciplinary incident review group

Further learning response decision guidance

For any incidents not specifically referenced within the above tables, the individuals with the accountability and authority to oversee incident management, response and learning will direct and support those reviewing incidents to select the most appropriate learning response.

These roles and responsibilities are set out with the organisational Patient Safety Incident Response Policy document.

The decision about the most appropriate and proportionate will arise from a balanced consideration of the principles outlined in Appendix 1.

Templates for the learning responses will be in Appendix 2-6, when they have been agreed at Quality Governance Group.

Appendix

Appendix 1: Learning response objectives

Objectives of Learning Responses		
Learning to inform improvement	**Improvement based on learning**	**Assessment to determine required response**
Where contributory factors are not well understood, and local improvement work is minimal	Safety issue/incident type is well understood (e.g., as past incidents have been thoroughly investigated and national/local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness), therefore resources are better directed at improvement rather than investigation	Issues or incidents where it is not clear whether a learning response is required
Learning response tool options:	**Learning response tool option:** 72 Hour Review	**Learning response tool option:**

72 Hour review that follows key lines of inquiry linked to the incident type/speciality Multidisciplinary team reviews Swarm Huddles After Action Review	Thematic review Horizon scanning	Structured judgement review 72-hour review