Patient safety incident response plan

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Contents

Introduction

The national Patient Safety Incident Response Framework (PSIRF) is a driver for change. It encourages us, as healthcare providers to think and respond differently when a patient safety incident occurs. Unlike previous frameworks, it is a whole system change which gives us responsibility for the entire incident response process, encouraging an open and just culture.

This Patient Safety Incident Response Plan sets out how Medway Community Healthcare (hereafter referred to as MCH) intends to respond to patient safety incidents over the next 12 months. The Plan is not a permanent rule that cannot be changed; indeed the expectation is that it will evolve. MCH will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This is the second year of our PSIRF journey so will be actively learning throughout the process. We may not get it all right at the beginning so we will monitor the effectiveness and impact of implementation, adapting our approach as needed.

- **we are caring and compassionate**
- **we deliver quality and value**
- **we work in partnership**

MCH at a glance (*use QR code for organisation structure chart)*

Our services

MCH services span across all ages from birth to end of life. They range from preventative and proactive support to keep people as well and independent as possible; through to complex care and support in individuals' own homes to prevent admission to hospital, or to support people following discharge from hospital. Our services are divided into the following operational pillars;

Pillar	Services
Planned Services	MSK, CAS, OT, SLT, N&D, Phlebotomy, Community Dental, Dentaline, Our Zone, Endeavour, Darland, Platters Farm, Community Stroke therapy team
Local Care	Community and Neighbourhood Nursing, Palliative Care, Cardiology, Respiratory, Diabetes, Tissue Viability, Wound and Leg Ulcer Clinics, Bladder and Bowel Service, Long Term rehab, Mental Health, Continuing healthcare, EOL Carers, EOL Facilitators, ILR, NUEOL
Urgent and Intermediate Care	Medocc, Urgent Response, IDT, D2A, Enablement, Short term rehab
Children's and Young People	Health Visiting, School Nursing, Community Nursing, wound clinic, medicines clinic, Continence, Speech and Language Therapy, Occupational Therapy, Physiotherapy, Podiatry, Neuro & Developmental, specialist assessment, Learning Disability nursing, special school nursing, ADHD, neuro disability
Corporate Pillar	Clinical Quality & Nursing, Patient Safety, Infection Prevention & control, Medication Management, Safeguarding, Research, Human Resources, Finance, Health and Safety, Estates, Information Technology, Project Management, communications, Executive Team

Our Locations

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

Ambley Green
Darland House
MCH House
Walter Brice Centre
Wisdom Hospice
Endeavour at Harmony House
Snapdragons Children's Centre
Rochester Healthy Living Centre
Lordswood Healthy Living Centre
Rainham Healthy Living Centre
Balmoral Healthy Living Centre
Keystone Centre

Medocc, MFT
Sheppey Hospital
Orchards
Dartford West Health Centre

Our Zone
Sevenoaks Hospital
Woodlands Health Centre

Defining our patient safety incident profile

The patient safety risk process is a collaborative process. To define the MCH patient safety risks and responses for 2025/26 we involved the following stakeholders and reviewed several different data sources.

- Staff through incidents reported on the incident reporting systems Zone Standard
- Senior staff across the organisation through consultation
- Subject matter experts including health and safety, information governance, risk, legal, customer experience and safeguarding.
- Patient groups through a review of complaints and claims as well as compliments

Data sources included:

- Analysis of the last year of incident data
- Key themes from complaints/claims/inquests
- Key themes identified from specialist safety and quality committees and forums. Safety Improvement Group, Pressure Ulcer, Falls Groups, IPC and Medicines sub-committees
- Learning from Patient Safety Incident Investigations (PSII), Structured Judgement Reviews (SJR's) and After Action Reviews (AAR's) including collaborative work with other organisations
- Medicines Management Sub Committee analysis of frequently occurring medication incidents
- Review of risks on the risk register

What this has meant for MCH as an organisation on looking at our data:

- Our top 5 incident categories are;
    - Pressure Ulcers
    - Medicines
    - Falls
    - Delays in care which include transfer of carer concerns (TOCC) with external providers
    - Information Governance (IG) e.g. documentation errors/allocation to wrong caseloads

- In the last 3 years we have had themes arising around

- Medication issues with communication and documentation
- TOCCs
- Communication issues
- Failure to escalate

- From this our top 3 priorities for improvement this year for PSIRF are
  - Pressure areas
  - Medication
  - Falls

- These areas have been chosen because they have also encompassed all of our identified themes across the chosen 3- year period data review.

Defining our patient safety improvement profile

Picture source: https://www.rightpatient.com/blog/patient-safety-improvement-hospitals-5-strategies/

Defining our patient safety improvement profile

Staff Culture: –

- Encourage an active reporting culture which includes incidents and near misses and good practice reported on the electronic incident reporting system, this includes utilisation of appreciative enquiries.
- PSIRF awareness is included at induction.
- PSIRF training plan for all levels of staff, up to and including opportunities for Level 3 & 4 for Patient Safety Specialist training.
- Staff engagement through the sharing of patient stories and learning opportunities.
- Evaluation questionnaires for staff following learning response engagement to help monitor and improve restorative just and learn culture within the organisation and nurture psychological safety.
- Regular Patient Safety team slots at service performance meetings to keep Patient Safety and Safety Culture initiative fresh and at the forefront of the change management process.

Senior leaders across the Organisation: –

- Through a series of discussions and meetings such the Integrated Quality and Performance Assurance Committee and Senior Management Team meetings
- Global review of HR policy and processes to meet the Restorative Just and Learn Culture Framework

Patient Groups: –

- Through a review of the thematic contents of complaints as well as the planned use of a patient experience group to review our implementation plan at MCH.
- Utilisation of Patient Safety Partner through collaboration with Medway Foundation Trust (MFT), to provide assurance and governance that the patient perspective is weaved through the whole framework and the patient voice can be heard.

The ICB and partner organisations: –

- Through partnership working with the ICB, at their regular meetings and through work with the Medway and Swale Health and Care Partnership patient safety and quality leads.
- Though continued engagement and invitation to GAIN and Quality events.
- Through attendance at our PSIRF governance and oversight meetings, Safety Improvement Group (SIG), Multi-Agency Review Group (MARG) and, via currently agreed, twice annual attendance at our Integrated Quality and Performance Committee (IQPAC).
- Detail of the PSIRP plan will be shared with ICB, annually for review

PSIRF: -

- Provides a list of national requirements for investigation. To enhance this list and to identify MCH priorities for patient safety improvement a review of patient safety data has been undertaken
- Integration of local reporting system with National reporting system – Learning From Patient Safety Events (LFPSE)

The Patient Safety Team: -

- Continues to engage with key stakeholders, both internal and external, reviews of data from various sources to arrive at a safety profile. During this process different methods of learning and improvement have been reviewed to inform our planning.

The Safety Improvement Group (SIG): -

- Responsible for the oversight of all safety improvement work, reporting to the Integrated Quality and Performance Assurance Committee. This group will monitor the effectiveness of the implementation of PSIRF to ensure patient safety improvements are delivered in several ways: -
- Through mandatory progress reviews of QI plans following learning responses to ensure learning is embedded and shared widely
- Review and escalation of any unresolved system issues identified as contributory factors during learning responses that may require Board input or risk management
- SIG project Charter – Oversight of all the key improvement areas identified as the 3 top priority themes for patient safety at MCH and areas included in our quality priorities (Pressure Ulcers, Falls, Medication, TOCC's, IG, Recognition of Deterioration (RED course), self-harm & suicide and learning from inquests)
- Key Improvement updates are fed back from their respective subgroups or committees for Pressure Ulcers, Falls and Medicines Management
- Oversight and sharing of QI projects and Improvement initiatives using new QI methodology Framework
- Presenting slots at GAIN – for teams to present their learning from incidents and allowing shared learning across the organisation

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e. incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

The table below sets out the local or national mandated responses. As MCH does not directly provide acute mental health or maternity services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types

Patient safety incident type	Required response	Anticipated improvement route
Deaths thought more likely than not due to problems in care	PSII	Safety actions to feed into patient safety improvement work
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	PSII	Safety actions to feed into patient safety improvement work
Incidents meeting the Never Events criteria 2018, or its replacement	PSII	Safety actions to feed into patient safety improvement work
Maternity and neonatal incidents meeting national referral criteria	Independent PSII (Healthcare Safety Investigation Branch or replacement)	Safety actions to feed into patient safety improvement work
Child deaths	Refer to Child Death Overview Panel for review A local PSII may be required	Learning from Panel
Deaths of persons with learning disabilities or an autistic person	Refer to Learning from Lives and Deaths People with a Learning Disability and autistic people (LeDeR) A local PSII may be required	Feedback from the LeDeR programme
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to female genital mutilation (FGM), Prevent	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and	Feedback from safeguarding reviews

Patient safety incident type	Required response	Anticipated improvement route
(radicalisation to terrorism), modern slavery and human trafficking or domestic abuse / violence	inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards A local PSII may be required	
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response	Safety actions to feed into patient safety improvement work

Our patient safety incident response plan: local focus

PSIRF has given us the opportunity to identify the areas of patient safety within MCH that would benefit from new improvement knowledge from learning responses. These areas and our planned approach are outlined in the table below.

Patient safety incident type or issue (alphabetical)	Planned response	Anticipated improvement route
Delay in Treatment		
Delay in treatment due to issues with diagnostics or onward referrals	AAR	Identification and management of any system failures identified Safety actions to feed into patient safety improvement work
Deteriorating patient		
Failure to escalate the deteriorating patient incident resulting in moderate or above harm, where there is suspected intentional harm, significant learning or a sequence of similar events have been identified in one key area	AAR	Identification and management of any system failures identified Safety actions to feed into patient safety improvement work
Discharge		
An incident that happens from a failure in the discharge processes where there is an adverse outcome of moderate harm or above, suspected system issues or significant system learning has been identified.	AAR/SJR	Identification and management of any system failures identified Safety actions to feed into patient safety improvement work
Healthcare associated or acquired infections		
Hospital associated infection – individual patients or outbreaks (attributable infections of consequence/importance like C diff or BSL)	AAR	Safety actions to feed into patient safety improvement work Creation of a local organisational action and addition to ongoing Organisation-wide improvement actions which is then shared with ICB to enable system wide learning

Patient safety incident type or issue (alphabetical)	Planned response	Anticipated improvement route
Medicines safety		
Delayed or omitted doses of critical medicines or high-risk medicines (Insulin, Controlled drugs and anticoagulation)	AAR/SJR Thematic review of medicines incidents	Shared learning through governance routes
Patient fall		
Patient falls resulting in significant head injury or death within four weeks. Patient falls resulting in a fracture or a cluster of falls in one area causing concerns	AAR/SJR/PSII The learning response methodology will be decided during the Hot Huddle, and recorded	Safety actions to feed into patient safety improvement work. Specific identified system failures or need to review policy and any significant learning to be reviewed and monitored by the Falls sub-group
Patients with mental health needs (older adult in our care home environment)		
Significant incident involving a patient with mental health needs such as self-harm, physical / chemical restraint, violence and aggression	AAR/SJR/PSII The learning response methodology will be decided during Hot Huddles, and recorded	Safety actions to feed into patient safety improvement work
Pressure ulcer		
Avoidable acquired pressure ulcer category 3/4 or deep tissue injury	AAR/SJR/PSII resolution where appropriate	Safety actions to feed into patient safety improvement work. Sharing of results of thematic reviews with ICB through patient safety reports
Multi-organisational and Cross System Patient Safety Incidents		
Patient safety incidents involving multi-agency or cross system working where significant learning can be identified and collaborated on to improve the whole system working	AAR/SJR/PSII	Safety actions to feed into patient safety improvement work. Themes and Trends to be shared with MARG and other multi provider meetings/H&CP meetings
Other		
Patient safety incidents resulting in moderate and above harm not included in the categories above with significant learning identified	AAR/SJR/PSII	Local safety actions

Patient safety incident type or issue (alphabetical)	Planned response	Anticipated improvement route
Patient safety incidents resulting in any level of harm not included in the categories above with no new learning identified	Completion of Zone Standard	Identify and manage system issues
Emerging patient safety incident themes	Possible PSII or thematic review	Safety actions to feed into patient safety improvement work

These agreed areas of local focus are not fixed and will be regularly reviewed. Within our resource analysis we have allowed capacity for additional ad-hoc patient safety incident investigations where new risks emerge or it is identified that learning and improvement can be gained from an investigation.

The table below shows that a range of different learning responses will be used for areas of local focus. The definitions of these different types of learning responses is provided below:

Learning response	Definition
After action review	An after-action review is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.
Patient Stories Reflective AAR	An After-action review with a twist – A purely reflective opportunity for staff to hold space from a patient's perspective – particularly following difficult patient journeys where complaints have identified specific areas of learning that require reflection for staff
Structured judgement review	The Structured Judgement Review (SJR) methodology provides a structured and replicable process to review deaths, which examines both interventions and holistic care giving reviewers a rich data set of information. The SJR methodology allows us to ask 'why' questions about things that happen, to enable learning and actions where required.
Patient safety incident investigation (PSII)	A PSII is undertaken when an incident or near-miss indicates significant patient safety risk and potential for new learning or system failures that need to be examined more closely with associated risks managed. Also undertaken in rare circumstances where there is suspected intentional harm. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions

Learning response	Definition
	are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.
Hot huddle	Following escalation of an incident of concern, the patient safety team will arrange a hot huddle with relevant attendees. At the huddle, identified risks are mitigated against and relevant actions are allocated; CQC notification, safeguarding, duty of candour and RIDDOR are all considered for appropriacy. Next steps are decided including any learning response deemed appropriate
Thematic review	A thematic review is a review which identifies patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative rather than quantitative data to identify safety themes and issues.
Electronic reporting system investigation	Local level look at any identified learning which is shared with the team. Themes and trends are fed into the patient safety governance process.

March 2025

MCH Clinical Quality Team