Patient safety incident response plan

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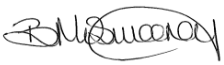
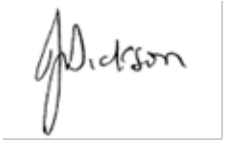
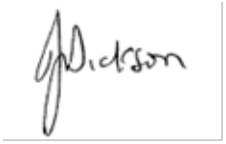
Author	**Briony McSweeney**	**Clinical Quality Partner**		**20/10/23**
Reviewer	**Clinical Policy & Practice Group / Clinical Governance Committee**	**Committee Members**		**15/11/23**
Authoriser	**Jo Dickson**	**Chief Clinical & Quality Officer**		**15/11/23**
Final Sign off approved by Lead ICB – Suffolk, North East Essex (SNEE ICB)				**23/11/23**

Ramsay Health Care

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Introduction

This patient safety incident response plan (PSIRP) sets out how Ramsay Health Care UK intends to respond and learn from patient safety incidents. This 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 in order to continually improve the quality and safety of the care we provide.

This plan will help us measurably improve the efficacy of our local patient safety investigations (PSI's) by:

a. refocusing patient safety investigation towards the rigorous identification of interconnected causal factors and systems issues

b. focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents

c. transfer the emphasis from the quantity to the quality of PSIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents

d. demonstrating the added value available from the above approach

We have committed to improve patient safety through the Patient Safety Incident Response framework, supporting a systematic, compassionate and proficient response to patient safety incidents, ensuring the principles of openness, learning and continuous improvement.

The plan is underpinned by our trust policies on incident reporting RM-006 which is available to all staff via the organisations intranet site and which has been updated to reflect the Patient Safety Incident Response Framework (PSIRF) principles.

Our services

Ramsay Health Care UK has a network of 35 hospitals and day procedure centres around the United Kingdom providing a comprehensive range of clinical specialities to private and self-insured patients, as well as patients referred by the NHS. In addition, Ramsay also operates a mobile diagnostic imaging service. The mobile fleet consists of 7 MRI and 3 CT Scanners that travel the country to support 18 of the 34 Ramsay hospitals. Our facilities provide a wide range of specialised clinical services from routine to complex surgery, day case procedures, diagnostic services and physiotherapy.

Two of the hospitals provide care for Children between the ages of 3 and 18 and these are:

- Rivers Hospital in Sawbridgeworth
- Springfield Hospital in Chelmsford

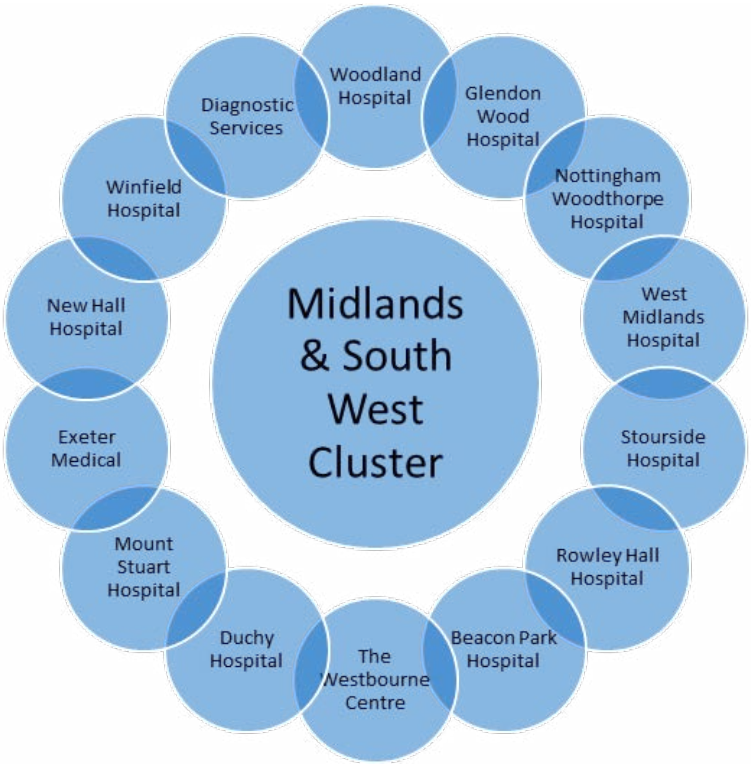
Four Hospital provide SACT services (Systemic Anti Cancer Treatment) and these are:

- Oaks Hospital in Colchester
- Yorkshire Clinic in Bradford
- Rivers Hospital in Sawbridgeworth
- Springfield Hospital in Chelmsford

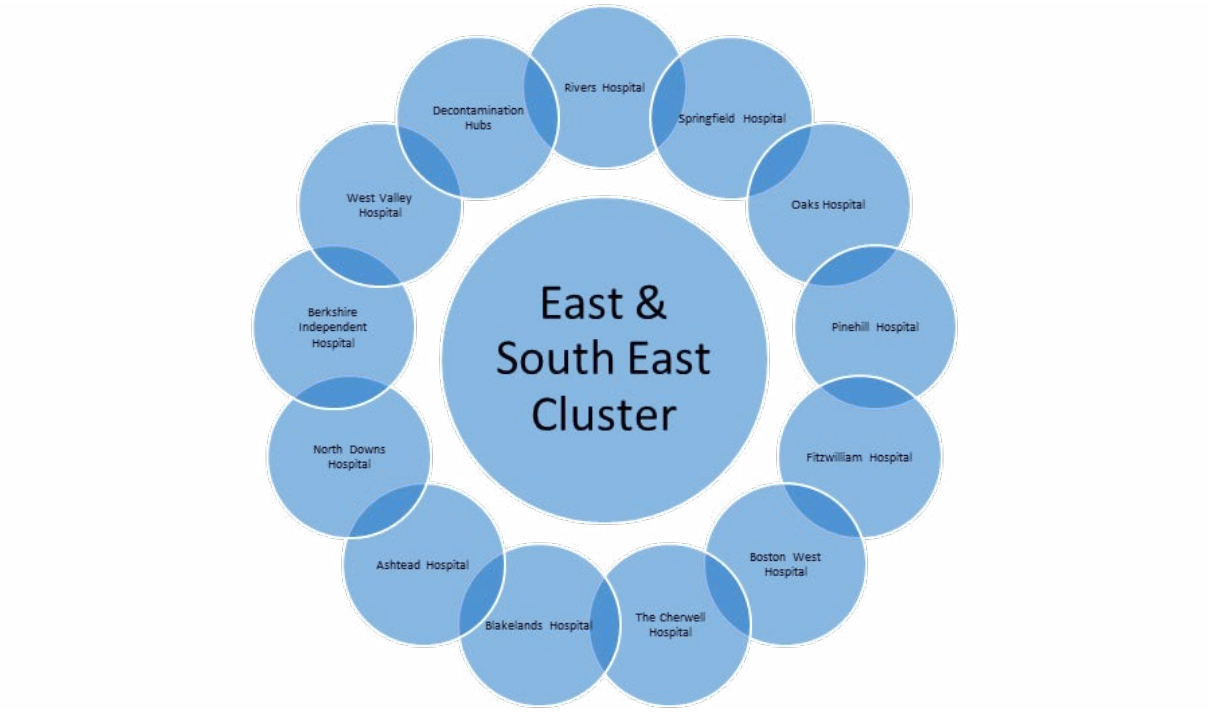
The 35 hospitals and day case facilities are split into 3 super clusters

North Cluster

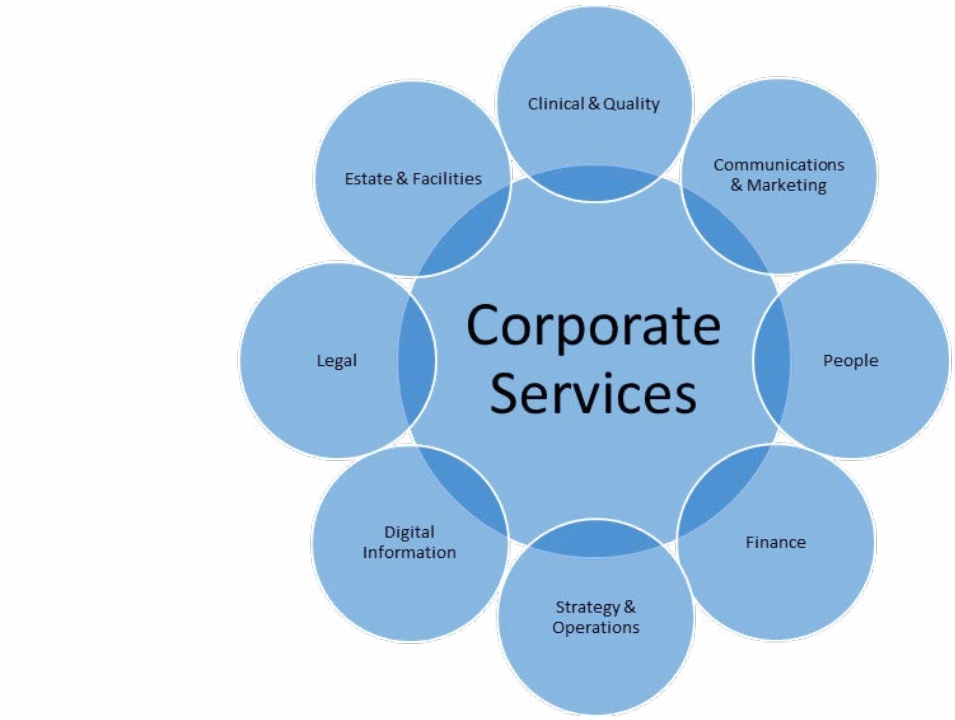
Midlands & South West Cluster



East & South East Cluster



Corporate Services



Our patient safety culture

As an organisation, Ramsay Health Care have worked hard to establish a restorative and just culture within the organisation.

As an organisation we are now focusing on the key priorities to enable effective cultural change through compassionate and inclusive leadership to foster a culture of psychological safety. This is essential to continue to develop high quality, safe patient care with a just, fair and learning culture. Staff affected by patient safety incidents should be supported with a compassionate and just approach ensuring there is no focus on blame or punitive measures for individuals involved in events. Working collaboratively across services and teams to ensure a supportive, fair and just approach in the management of incidents and reviews, that is consistent across all areas and teams.

Ramsay Health Care UK (RHCUK) recognises that promoting a culture of safety and reliability is a fundamental part of our risk management framework and quality initiatives. RHCUK has partnered with the cognitive institute to introduce a professional accountability framework based on the Vanderbilt University Medical Centre and Cognitive Institute, Patient and Professional Advocacy model. This is part of RHCUK's safety framework and culture.

RHCUK is committed to promoting a culture where feedback and speaking up for safety is encouraged, supported and welcomed. RHCUK appropriately addresses behaviour that undermines patient, consumer and employee safety, quality, reliability of care and accountability. This is done through the Cognitive Institute 'Speaking up for Safety' (SUFS) programme, online reporting tool and response system as part of our commitment to a culture of safety, reliability and accountability.

Ramsay Policy CM-005 raising a concern about patient safety also highlights the steps to take to escalate concerns about patient safety.

Defining our patient safety incident profile

The patient safety incident risks for Ramsay Health Care UK have been profiled using organisational data including:

- **Incident Reports:** Three years of data have been reviewed and a thematic analysis undertaken.
- **Organisational Risk Register:** Ramsay Health Care UK's Risk Register was reviewed, with a focus on risks related to patient safety and this was triangulated with incidents and complaint themes
- **Complaints:** Complaint themes were reviewed, and a thematic analysis undertaken which was triangulated with other data sources
- **National & Clinical Audit:** Outcomes and recommendations were reviewed and the themes triangulated with other data

The patient safety incident profile was defined with the collaboration of the following stakeholders

- **Staff -** Through the incidents reported on the incident management system
- **Senior Clinical Leaders -** Through governance committees such as Mortality & Morbidity, Medical Services Committee and the Clinical Governance Committee
- **Patient Groups -** Through a review of the thematic contents of complaints and patient feedback
- **Commissioners / ICB Partners -** Through local partnership working at site level

Local patient safety risks related to national priorities have been defined in the list of risks covered by national priorities that Ramsay Health Care UK anticipates will require a response in the next 12 - 14 months. Table 1 sets out the full list of national priorities that require a response.

The top local patient safety risks have been defined as the list of risks identified through the data review and stakeholder approach. These local risks represent an opportunity for learning and improvement. Table 2 lists the Ramsay Health Care UK top local patient safety risks.

Defining our patient safety improvement profile

Ramsay Health Care UK has a programme of patient safety improvement across the organisation. The clinical governance framework enables a robust assurance process, providing assurance that improvements are being made, embedded and sustained.

The improvement programmes and priorities for Ramsay Health Care UK were identified through an analysis of incident reporting over the last three years and detailed thematic analysis. Key themes from complaints and themes identified from various safety and quality committees were also reviewed along with the most frequently occurring medication incidents reported at the Drugs and Therapeutics Committee:

- Deteriorating Patient
- Falls Prevention
- VTE Reduction
- Infection Prevention and Control
- Acute Kidney Injury
- Hyponatraemia
- Bowel Obstruction
- Medications Management

The key priorities are discussed and assurance given through the following groups and committees:

- Patient Safety Incident Review Group
- Mortality & Morbidity Group
- Clinical Practice & Policy Group
- Resuscitation Committee
- Theatres Working Group
- Physiotherapy Working Group
- Falls Working Group
- Clinical Governance Committee
- AKI Working Group
- Infection Prevention Control Committee
- Drugs & Therapeutics Committee
- Diagnostic Governance Committee
- Medical Services Committee
- SACT Committee

There is currently improvement work within Ramsay Health Care UK which is focusing on

- VTE Reduction
- Hyponatraemia / AKI
- Bowel Obstruction
- Falls

With further work to focus on the deteriorating patient, medication management and infection prevention control issues causing significant infections.

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.

The table below sets out the local or national mandated responses. Ramsay Health Care UK does not directly provide mental health or custodial services or maternity or neonatal services but may be a secondary participant in mental health rather than a lead for these incident types.

Table 1

	Patient Safety Incident Type	Required Response	Anticipated Improvement Route
1	Incidents meeting the Never Events Criteria	Locally Led PSII	Patient Safety Incident Review Group Mortality & Morbidity Group Clinical Governance Committee
2	Deaths though more likely than not due to problems in care (incident meeting the learning from deaths criteria for Patient Safety Incident Investigations (PSII))	Locally Led PSII	Mortality & Morbidity Group Clinical Governance Committee
3	Incident in Screening Programmes	PSII	Patient Safety Incident Review Group Mortality & Morbidity Group Clinical Governance Committee
4	Death of a person with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents / problems in the health care provided by the NHS	LeDeR Review – All deaths of a person with learning disabilities must be referred to LeDeR Locally led PSII as directed by LeDeR	Patient Safety Incident Review Group Mortality & Morbidity Group Clinical Governance Committee Safeguarding
5	Child Death	SUDIC	Paediatric Governance Patient Safety Incident Review Group Mortality and Morbidity Group Clinical Governance Committee
6	Safeguarding Incidents	As recommended by Safeguarding Requirements	Patient Safety Incident Review Group Clinical Governance Committee
7	Notification of Infectious Disease	Following National Guidelines	Infection Control Committee
8	Information Governance	Following National Guidelines	Clinical Governance Committee Operations Board
9	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where the death may be linked to problems in care (incidents meeting the Learning from Deaths Criteria)	Locally Led PSII	Mortality & Morbidity Committee Clinical Governance Committee Safeguarding

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 Patient Safety Incident Investigation PSII) require a locally led PSII.

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Deterioration of a patient and transfer out requiring level 2 or 3 care (HDU or Critical Care)	Patient Safety Incident Investigation (PSII)	Identify Trends and Improvements Patient Safety Incident Review Group Mortality & Morbidity Group Clinical Governance Committee
Deterioration of a patient requiring transfer out to an NHS Hospital for further management and treatment (Other setting not level 2 or 3)	Appropriate Learning Response Tool such as AAR, Swarm Huddle / Hot Debrief, MDT Review at Patient Safety Incident Review Group to determine if PSII is required Thematic Analysis if required	Identify Trends and Improvements Patient Safety Incident Review Group Mortality & Morbidity Group Clinical Governance Committee
Falls with Harm – Inpatient falls resulting in a bone fracture or haemorrhage	Hot Debrief / Swarm Huddle and AAR Appropriate learning response tool and then review at the Patient Safety Incident Review Group to determine if a PSII is required	Falls Working Group Patient Safety Incident Review Group Clinical Governance Committee
Venous Thromboembolism Incident	Thematic Analysis Appropriate Learning Response Tool such as Clinical Record Review / AAR or no response as ongoing improvement workstream	VTE Review Group Mortality & Morbidity Group Clinical Governance Committee
Acute Kidney Injury / Hyponatraemia – Patients transferred out with Acute Kidney Injury or for further management of hyponatraemia	Thematic Analysis Appropriate learning response tool and then review at the Patient Safety Incident Review Group to determine if a PSII is required or no further response necessary due to ongoing improvement workstream	AKI Working Group Patient Safety Incident Review Group Mortality and Morbidity Meeting Clinical Governance Committee
Bowel Obstruction	Thematic Analysis Appropriate learning response tool and then review at the Patient Safety Incident Review Group to determine if a PSII is required or no response necessary due to ongoing improvement workstream. PSII	Patient Safety Incident Review Group Mortality & Morbidity Meeting Clinical Governance Committee
Medication Incidents – Errors in prescribing and omission of doses leading to harm or potential for harm	Appropriate learning response tool and then review at the Patient Safety Incident Review Group to determine if a PSII is required PSII	Drugs & Therapeutics Committee Patient Safety Incident Review Group Clinical Governance Committee
Medication Incidents – Errors involving anticoagulation leading to harm or potentials for harm	Appropriate learning response tool and for review at the Patient Safety Incident Review Group to determine if a PSII is required PSII	Drugs & Therapeutics Committee Patient Safety Incident Review Group Clinical Governance Committee

Other incidents which have resulted in moderate to severe harm or a near miss where there is potential for wider learning including significant infections.	Appropriate learning response tool and for review at the Patient Safety Incident Review Group to determine if a PSII is required PSII	Inform ongoing improvement efforts through review and identification of trends Patient Safety Incident Review Group Mortality & Morbidity Group Clinical Governance Committee
Medication incidents – Adverse reactions	Thematic Analysis Appropriate learning response tool and for review at the Patient Safety Incident Review Group to determine if a PSII is required	Diagnostic Governance Committee Patient Safety Incident Review Group Drugs & Therapeutics Committee
Radiation Incidents and MRI safety incidents	PSII	Diagnostic Governance Committee Radiation Protection medical Exposure Committee

Where an incident does not fall into the categories above; an investigation and / or review method described in Appendix 1 may be used by the local team.

The learning response method used must be documented on the Radar incident reporting system.

All incidents which meet the notifiable safety incident criteria under the Health and Social Care Act 2008 (Regulated Activities) regulation 20 will be subject to duty of candour. This is any unintended or unexpected incident which occurred in respect of a service user during the provision of a regulation activity, that in the reasonable opinion of a health care professional could result in, or appears to have resulted in:

- The death of a service user where the death relates directly to the incident rather than to the natural course of the service users illness or underlying condition or
- Severe harm, moderate harm or prolonged psychological harm to the service user.

Further information related to duty of candour is reflected in Ramsay Policy RM-010 ‘Being Open’ and this has been updated to reflect PSIRF principles.

Learning Responses should also include good or positive care which can also be shared locally, organisationally and cross systems. Some incidents may not require a response if ongoing improvement work is in place and there is no learning identified.

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Glossary

PSII - Patient Safety Incident Investigation	PSII's are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care to our patients.
PSIRF - Patient Safety Incident Response Framework	PSIRF is designed to enable a risk based approach to responding to patient safety incidents, prioritising support for those affected, analysing incidents and reducing future risk
PSIRP - Patient Safety Incident Response Plan	The local plan for how Ramsay Health Care UK will carry out PSIRF locally. This has been developed through a collaborative and data driven approach
Never Events	Patient Safety Incidents that are considered to be preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers
AAR - After Action Review	A model of emergent learning in which individuals are actively involved in self learning and self discovery and build their own understanding of how to improve performance.
Swarm Huddle	Swarm Huddles are used to identify learning from patient safety incidents. Immediately after an incident staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.
Thematic Analysis	A method of analysing qualitative data and identifying patterns in data to help answer questions, show links or identify issues
Multidisciplinary Team Review (MDT)	The MDT review supports teams to identify learning from multiple patient safety incidents and agree through open discussion the key contributory factors and system gaps in patient safety incidents.

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