Patient Safety Incident Response Plan

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1 Introduction

1.1 Purpose

1.1.1 The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. As a provider of health care services, the British Red Cross (BRC) has adopted the framework UK wide to be consistent in supporting a systematic, compassionate, and proficient response to patient safety incidents; anchored in the principles of openness, learning and continuous improvement.

1.1.2 This Patient Safety Incident Response Plan (PSIRP or Plan) sets out how the BRC intends to respond to patient safety incidents over the next 12 to 18 months in line with the PSIRF. The Plan may be revised over that period based on learning or themes identified. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

1.1.3 This Plan will help us complete effective local patient safety investigations by:

a) focusing patient safety investigation towards the rigorous identification of interconnected causal factors and system 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) emphasising the quality of investigations using system-based approaches, such that it increases our stakeholders' (notably people we support, their families and carers alongside our staff and volunteers) confidence in the improvement of patient safety through learning from incidents.

d) demonstrating the added value available from the above approach.

1.2.4 There are several other types of incident investigation which, unlike Patient Safety Incidents, may be conducted in line with BRC, Charity Commission or external regulatory requirements and will be updated where necessary in line with BRC incident policy. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations.

1.2 Scope

1.2.1 A Plan is a requirement of each provider or group/network of providers delivering NHS-funded care.

1.2.2 The document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF), which sets out the requirement for this plan to be developed - NHS England » Patient Safety Incident Response Framework.

1.2.3 We have developed the planning aspects of this Plan with the assistance and approval of one of our lead health commissioners.

1.3 Strategic aims

1.3.1 Improve the safety of the care we provide to the people we support and improve their (and families/ carers) experience.

1.3.2 Further develop systems of care to continuously improve quality and efficiency.

1.3.3 Improve the use of valuable healthcare resources.

1.3.4 Improve the working environment for staff and volunteers in relation to patient safety incidents.

1.3.5 Act on feedback from the people we support, their families/carers and our staff and volunteers in relation to patient safety and associated investigations.

1.3.6 Develop a climate that supports a just culture and an effective learning response to patient safety incidents.

1.3.7 Develop a framework around patient safety investigation and alternative responses to patient safety incidents, which promotes ownership, rigor, expertise and efficacy.

1.3.8 Make more effective use of current resources by focussing on high quality investigations with a more proportionate response to patient safety incidents. The aim is to:

- make investigations more rigorous and, with this, identify causal factors and use system-based approaches to make systemic improvements.
- compassionately engage service users, families, carers, staff and volunteers in investigation and other responses to incidents, for better understanding of the issues, causal factors and how their experience could have been improved.
- develop and implement improvements more effectively.

1.4 Our services

1.4.1 BRC provides a range of health and social care services across the UK which include:

Health transport – non-emergency patient transport and assisted discharge services which support patients travelling to and from healthcare facilities or returning home from hospital. Assisted discharge supports patients no longer requiring hospital care and enables faster and safer discharges. Patient transport services offer low level clinical care, oxygen therapy and monitoring. They have the capability to support end of life and high body mass index (BMI, e.g. bariatric) patients and are regulated by the Care Quality Commission in England. Other activities such as home assessments, support with practical task, signposting and shopping can also be included.

Regulated Care - We provide short-term care and support to individuals in their own homes, in accordance with their specific needs and preferences. Activities typically include supporting medicine adherence , personal care, conditional specific support, and emotional support promoting independence and improving overall wellbeing. We also provide support for end-of-life patients. These services are regulated by the Care Quality Commission in England.

Accident and Emergency Department Support - Emotional and practical support to people, their families or carers, while in the accident and emergency department. We complete practical activities that support NHS colleagues with the efficient operating of the accident and emergency department. Transport home can also be included as part of this service.

Support at Home (including hospital at home) – One to one support, typically lasting between 4-12 weeks, to increase a person's resilience and independence following an illness, injury or hospital admission. It can also be preventative to support people to maintain their wellbeing. Activities include, personalised goal setting, home risk assessments, income maximisation, social visits, practical tasks, shopping and connecting people to local resources. For Hospital at Home, support includes making people feel engaged and safe in their own care by also supporting with digital health monitoring devices as well as emotional and practical support.

Health coaching, social prescribing and High Intensity Use services – provide programmes employing a coaching model either on a one to one or group basis, which are focussed on addressing unmet social needs in a holistic manner. HIU programmes adopt a de-medicalised, de-criminalised approach for individuals who frequently access urgent and emergency care. Across all health coaching, social prescribing and HIU service, we advocate for people we support and work to improve their access to statutory and community-based services.

2 Defining our patient safety incident profile

2.1 Purpose

2.1.1 Patient safety risks were assessed collaboratively by an internal PSIRF working group.

2.1.2 The patient safety incident risks for BRC have been profiled using organisational data from recent patient safety incident reports, serious incidents and investigations. These are stored in BRC's Datix Cloud IQ (DCIQ) system.

2.1.3 Stakeholders were approached to give insight to areas of concern regarding risk to patient safety. Included in engagement were frontline staff and managers and subject matter experts. We will continue to engage our staff with the assistance of Patient Safety leads across the Health & Care Directorate

2.1.4 Resources utilised for this data include BRC's incident management system, Datix Cloud IQ (DCIQ).

2.1.5 BRC aims to incorporate wider patient perspective into future PSIR planning through patient feedback and incorporate key themes from complaints, claims and inquests.

2.1.6 Future versions of the plan will also take account of output from quality and safety reviews and audits within the services.

2.1.7 From our data analysis and stakeholder engagement the following patient safety profiles were identified and agreed

2.2 Locally defined profiles

2.2.1 The current top priorities/risks in our patient profile are as follows:

Identified Priority	**Description**	**Source of evidence / Data**
Injury, harm or near miss involving moving and assisting of people	Incidents related to the manual handling of a person or supporting them to move that has caused, or could have caused, them harm.	Incidents / Stakeholder Engagement
Medication Issue	Incidents involving medications that caused harm, or could have caused harm, to a person we support. This may involve (but is not limited to)	Incidents / Stakeholder Engagement

	handling, storage, transportation, transfer, disposal, administration or missed doses of medication. The refusal of medication, administration by non-authorised methods and any issues with medication documentation and record-keeping	
Unexpected health deterioration or death of a person we support	Where a person we support dies unexpectedly, or their health deteriorates unexpectedly, during service delivery or within 28 days of our involvement	Incidents / Stakeholder Engagement
Communication, Referral or handover issue	Where the incident caused (or could have caused) harm	Incidents / Stakeholder Engagement

3 Our Patient Safety Response

3.1 Aim of patient safety investigation

3.1.1 Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that lead to patient safety incidents. These findings are then targeted with strong systemic improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

3.1.2 There is no remit to apportion blame or determine liability, preventability or cause of death.

3.1.3 Selection of patient safety incidents for investigation

3.1.4 In view of the above, the selection of incidents for investigation is based on the:

a) actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds)

b) likelihood of recurrence (including scale, scope and spread)

c) potential for new learning in terms of:

- enhanced knowledge and understanding of the underlying factors;
- improved efficiency and effectiveness (control potential); and
- opportunity to influence wider system improvement.

3.1.5 Incident investigation and reporting may also be influenced by external regulatory or Charity Commission requirements.

3.2 Timescales for patient safety investigation

3.2.1 Where a patient safety investigation for learning is indicated, the investigation must be started as soon as possible after the incident has been identified.

3.2.2 Patient safety investigations should ordinarily be completed within one to three months of the start date.

3.2.3 Where a longer timeframe is required for completion of the patient safety investigation this can be agreed by the organisation in consultation with the patient/family.

3.2.4 No local patient safety investigation should take longer than six months. A balance must be drawn between conducting a thorough investigation, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

3.2.5 Learning captured through patient safety investigations will be fed into the national health and care improvement plan, which is held by the Health and Care Quality Assurance Group, and overseen by the Health and Care National Management Team. The Quality Assurance Group will monitor progress in implementing learning outcomes, including agreeing who and how learnings should be shared, and setting any necessary

timeframes in which this should be undertaken. Internally we facilitate professional network who would also be a key contributor in the learning and improvement process.

3.2.6 In addition to this, learnings will also be fed into our Quality Framework, which will assess the extent to which learnings have been embedded into processes and practice, and provides an ongoing framework for assessment and improvement planning.

4 Our patient safety incident response plan: national requirements

4.1 Nationally defined incidents

4.1.1 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). The BRC patient safety review group will "triage" and then respond to such incidents accordingly.

National Priority	**Response**
Incidents meeting the Never Events criteria	PSII led by national PSIRF group
Death thought more likely than not can be attributed to BRC support or neglect	PSII led by national PSIRF group
An incident that is in breach of fundamental safeguarding criteria. This encompasses instances where neglect or abuse is suspected, critical procedures are not followed, or there is a failure in duty of care resulting in physical, emotional, or psychological harm.	PSII led by national PSIRF group

4.1.2 From our data and analytics, as an organisation we would expect 3 Patient Safety Incident Investigations (PSII) each year where local or national requirements have been met. Findings from these reviews will help to provide key insights and learning opportunities, that will help to inform continuous improvement. A summary report will be produced annually to highlight themes and areas of learning.

4.1.3 To improve our ability to deliver against the PSII requirements, specific staff will be trained to oversee the delivery of PSII standards and support the sign off of all PSII's. Staff will also be trained in system-based approaches to support either leading or reviewing learning responses and PSII.

5 Our patient safety incident response plan: local focus

5.1 Locally defined incidents requiring investigation

5.1.1 Based on a review of the incident reporting profile for the period 2022-2023 priorities have been set by BRC for patient safety investigation for the period April 2024 to March 2025.

5.1.2 The BRC patient safety review group will review and "triage" potential incidents for investigation to determine what type of learning response (which may include a full PSII) should be undertaken. These are expected to fall into the following categories:

Emergent patient safety incident (requiring PSII)

An unexpected patient safety incident which signifies an extreme level of risk for service users, families and carers, staff, volunteers or organisations, and/or where the potential for new learning and improvement is so great (for example within or across a healthcare service /pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

Predefined emergent patient safety incidents (requiring PSII)

Key patient safety incidents for investigation in the priority areas already identified by BRC in line with the following criteria:

a) actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)

b) likelihood of recurrence (including scale, scope and spread)

and there is potential for new learning in terms of:

- enhanced knowledge and understanding
- improved efficiency and effectiveness (control potential)
- opportunity for influence on wider systems improvement.

5.1.3 **Patient safety incidents (outside of criteria in 5.1.2)**

For other incidents we will use specific patient safety review tools (see further information in Appendix) to enable a learning response following the triage process. We propose to manage these at a local level along with ongoing thematic analysis via our existing assurance processes which may lead to new or supplement existing improvement work and audit. The specific patient safety review tools that the organisation have agreed to adopt are as follows:

- Post Incident Huddle
- Patient Safety Audit/Thematic Review

5.1.4 Finally, it is possible the triage may determine that the incident could be managed through our standard Datix incident recording investigation approach.

5.1.5 The type of response may also depend on other factors identified at the triage stage, including:

- The views of those affected, including patients and their families
- Capacity available to undertake a learning response
- What is known about the factors that lead to the incident(s)
- Whether improvement work is underway to address the identified contributory factors
- Whether there is evidence that improvement work is having the intended effect/benefit
- If BRC is satisfied that risks are being appropriately managed.

5.1.6 In 2024, the British Red Cross would expect the following response types against our patient safety incident profile, where there is potential for new learning, (noting that triage will establish the most appropriate response).

5.1.7 These themes have been identified using our incident reporting, complaints and stakeholder engagement with:

- Subject matter experts
- Health operation managers
- Frontline staff

5.1.8 The learning response approach will be based upon the four strategic aims of PSRIF:

Compassionate engagement: we will meaningfully involve those affected, where they wish to be involved.

Systems based approach: use systems based tools to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement

Proportionate response: the response will be proportionate to the level of impact on people we support, and we will implement PSII in incidences of high impact to learn and improve.

Supportive oversight: we will work collaboratively, building a culture of psychological safety and mutual understanding to provide effective governance of patient safety incidents which support improvement.

Patient Safety Incident Type	Planned Response Type	Anticipated Improvement Route
Injury, harm or near miss involving moving and assisting of people	Huddle or PSII (dependant on incident and scope for organisational learning)	Create local and organisational actions and feed these into the Health & Care Quality Assurance steering group
Medication issue: Wrong medication or dose administered*/ prompted: Causing harm and (where there is new organisational learning)	PSII	Feed into a themed review on omitted or over medicating in 2024 as part of our improvement activities. Create local and organisational actions and feed these into the Health & Care Quality Assurance steering group
Medication Issue: Wrong medication or dose administered*/ prompted: Potential or no harm and where there is new local learning	Huddle	
Medication Issue: Patient error identified by BRC team	Huddle	
Unexpected health deterioration or death of a person we support	Huddle or PSII (dependant on incident and scope for organisational learning)	Create local and organisational actions and feed these into the Health & Care Quality Assurance steering group
Communication, Referral or handover issue	Huddle	Create local and organisational actions and feed these into the Health & Care Quality Assurance steering group
Other incidents which have resulted in moderate to severe harm or a near miss where there is potential for wider learning.	Huddle or PSII (dependant on incident and scope for organisational learning)	Relevant improvement work-stream. Shared learning at Quality and Safety Group.
Other incidents / prevalent themes which have resulted in minor or no harm but there is potential for wider learning.	Huddle	Local action plans and improvements. Shared learning at Quality and Safety Group.

5.1.9 Future iterations of the local requirements and planned response types will be assessed from a range of sources which may include:

- Aggregated data on patient safety reporting
- Audit and review findings
- PSIIs
- Progress against and feedback from implementing the PSIRP
- Annual reporting
- Results from monitoring improvement plans
- Results of surveys from patients/families/carers
- Results of surveys and/or feedback from staff.

6 Appendix 1- Glossary

Datix

The system used to record and manage incidents within the BRC. This is also used for non-patient safety incidents and maybe closed with a range of outcomes from narrative and reporter feedback, through to investigations including using the PSIRF.

PSII - Patient Safety Incident Investigation

PSIIs are conducted by initially developing key lines of enquiry, the stakeholders involved, and what is already known about the incident. The PSII will then identify wider or underlying system factors that contributed to the incident. PSII will use compassionate engagement principles and the findings used to identify improvements, including by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Final recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for the people we support.

PSIRF - Patient Safety Incident Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response Plan

Our plan sets out how we will carry out the PSIRF including our list of priorities. These have been developed with operational teams and compliance leads supported by analysis of operational data.

Post Incident Huddle

A team-based method of understanding the event (what happened and how it happened but in the context of the real-world situation) through a series of facilitated prompts. It aims to capture learning from these to identify improvement opportunities.

Patient Safety Audit/Thematic Review

A review of a series of cases (of the same incident type) using audit or thematic methodology to identify where there is an opportunity to improve and/or more consistently achieve specific standards (e.g. in a policy or guideline). This is likely to use the same system prompts as the huddle but at an aggregated level. A valuable way of accomplishing thematic analysis of patient safety investigation findings is to select a few (3–6) very recent and typically similar incidents and investigate each one with skill and in detail to determine the common interconnected contributory and causal factors, on which effective improvements can be designed. Importantly, recent incidents will allow information gathering and analysis about the system as it currently stands

Never Event

Patient safety incidents that are wholly preventable, where guidance or safety recommendations are already in place and have been implemented, that failed to prevent the incident from occurring.