The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Title:	Patient Safety Incident Response Plan		
Unique Identifier:	SOP418	**Document Type:**	Procedure
Version Number:	1.0	**Status:**	Approved
Responsible Director:	Chief Nurse & Patient Safety Officer		
Author:	Kirsty Foskett, Head of Clinical Governance, Quality and Patient Safety Specialist		
Scope:	All Staff, Trust-wide		
Replaces:	Management of Serious Incidents Policy V8.0		
To be Read in Conjunction with the Following Documents:	Patient Safety Incident Response Policy Incident Policy Duty of Candour Policy Complaints Policy		
Keywords:	patient safety, incidents, quality improvement, learning response, Datix		

Considered By Responsible Director:	Chief Nurse & Patient Safety Officer	**Date Considered:**	22/06/2023
Endorsed By:	Patient Safety Group and Quality & Safety Committee	**Date Endorsed:**	13/06/2023 22/06/2023
Approved By:	Board of Directors	**Date Approved:**	06/09/2023
Issue Date:	01/10/2023	**Review Date:**	01/04/2025
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

Patient Safety Incident Response Plan

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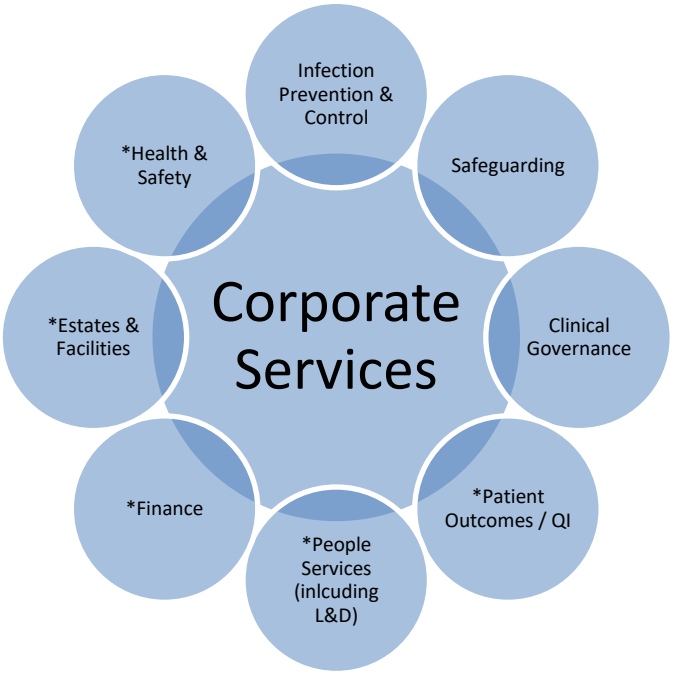
Introduction

This patient safety incident response plan sets out how The Robert Jones & Agnes Hunt Orthopaedic Hospital intends to respond to patient safety incidents over a period of 12 to 18 months. 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.

Our services



Defining our patient safety incident profile

Stakeholder Engagement

A project group was established in August 2022, to implement the Patient Safety Incident Response Framework. To establish the group key stakeholders were identified as the following:

- Patient Safety Specialists
- Clinical Governance Team
- Nursing and AHP (Allied Health Professionals) representation from the delivery units
- Information and Performance Team
- Quality Improvement Practitioner
- Subject matter leads relating to;
    - Infection Prevention Control
    - Falls
    - Tissue Viability
    - Medicines Safety
    - Resus and Deteriorating Patient

Data Sources

The group used a variety of sources to identify the safety incident profile, reviewing information from the previous two to three years. This included:

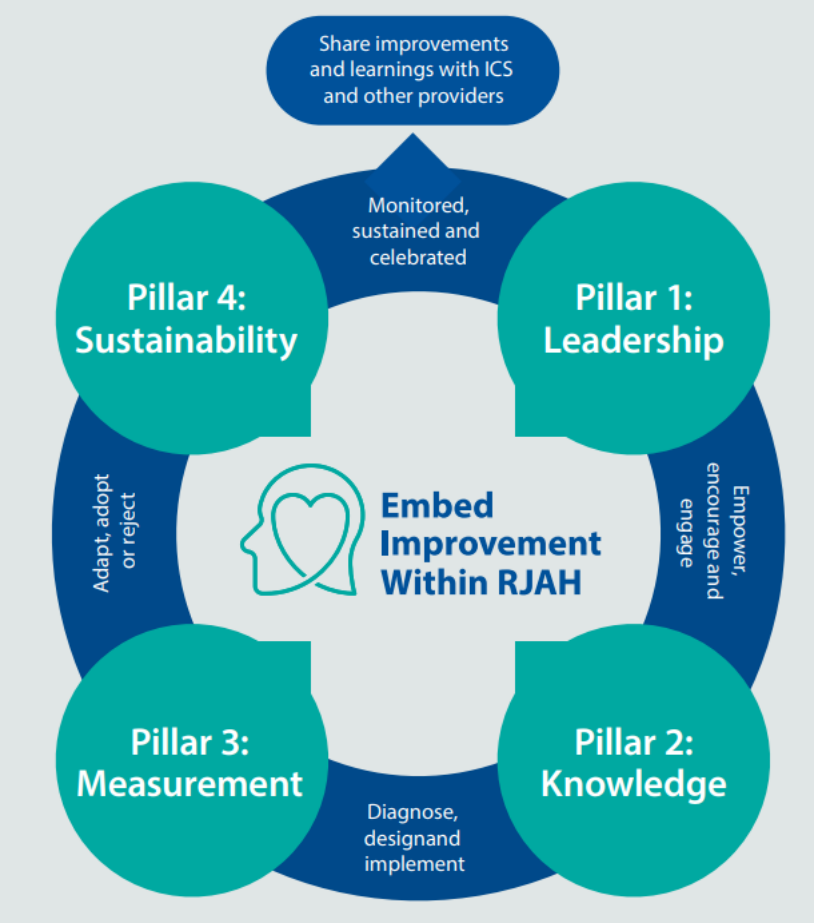
- Datix incident profiles
- Key performance indicators
- Reported Serious Incidents or Never Events
- Patient experience data

- Clinical Audit
- Trust Risk Registers

Defining our patient safety improvement profile

When defining our patient safety improvement profile, the group explored local, regional, and national improvement work that was already taking place. Through this review it was decided patient safety events relating to falls and medications would be viewed through the lens of improvement based on the Trust's learning response. The group acknowledged that the Trust are aware of these incident types and factors were understood but improvement needed to focus on recurrent themes.

During 2022/23 the Trust have also developed a Quality Improvement Framework which describes how quality improvement will support the Trust in striving towards our vision of aspiring to deliver world class patient care. World class does not come easy; therefore, it is vital we pick up the pace in moving towards embedding continuous improvement throughout every aspect of RJAH. The framework recognises that all staff have a part to play at RJAH in delivering that vision, and that part includes improvement. The below diagram sets out an improvement model to embed improvement within RJAH:



Our patient safety incident response plan: national requirements

There are several national priorities outlined by NHS England, however as RJAH is a specialist orthopaedic Trust, the national priorities outlined below are those considered specific to this Trust.

Patient safety incident type	Required response	Anticipated improvement route
National Priorities		
Incidents meeting the national Never Events criteria 2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)	Patient Safety Incident Investigation	Organisational Safety Improvement Plan
A patient death thought more likely than not due to problems in care, as indicated by NHS England Learning from Deaths guidance. ngb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)	Patient Safety Incident Investigation	Organisational Safety Improvement Plan

National priorities are outlined below, require an external escalation, where the Trust may need to contribute to an investigation. A locally led Patient Safety Incident Investigation (PSII) may be required dependent upon the circumstances surrounding the patient safety event.

- Child Death should be reviewed to the Child Death Review Panel
- Death of persons with Learning Disabilities, need to be referred to the Learning Disability Mortality Review (LeDeR) programme.
- Safeguarding, under the following categories must be referred to local authority safeguarding lead.
    - 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.
    - If the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response*	Anticipated improvement route
Unplanned admissions to critical care due to clinical deterioration from inpatient wards or theatre	Datix investigation and MDT (multidisciplinary team) Review at the HDU (High Dependency Unit) Well-Led Meeting, reporting findings to the Patient Safety Working Group.	Co-production of safety improvement actions managed on a local/organisational safety improvement plan.
Nosocomial Outbreaks	After Action Review	Co-production of safety improvement actions managed through the IPC (Infection Prevention and Control) improvement plan.
Surgical Site Infections	Individual cases assessed against the 'One together' audit tool, with a bi-annual review of the information collected and co-production of improvement actions	Co-production of safety improvement actions managed through the IPC improvement plan.
Falls	Quarterly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan
Medication Events	Quarterly thematic review (incorporating SEIPS Model into the investigation of Datix)	Use the theme identified to focus the required quality improvement, monitored through the organisational safety improvement plan
Incidents of VTE (Venous Thromboembolism)	Data collection and bi-monthly MDT Review of findings and co-production of improvement actions	Co-production of safety improvement actions managed on a local/organisational safety improvement plan.
Assessment of incidents outside of the identified priorities	Proportionate response dependent upon the	Co-production of safety improvement actions managed

	circumstances surrounding the patient safety event	on a local/organisational safety improvement plan.

*The Systems Engineering Initiative for Patient Safety (SEIPS) model will be used as a framework to guide all learning responses.

Version Control Sheet

Record of Amendments to: Patient Safety Incident Response Plan				
Amendments approved by:				**Date**
Section number	**Amendment**	**Deletion**	**Addition**	**Reason**