HCAHealthcare UK

Patient Safety Incident Response Plan (PSIRP)

2022-2024

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Introduction

This patient safety incident response plan (PSIRP) sets out how **HCA Healthcare (HCA UK)** will respond and seek to learn from reported patient safety incidents over the next 12 to 18 months.

This plan outlines the processes that must be followed to meet the requirements of the National Patient Safety Incident Response Framework (PSIRF) and is underpinned by HCA UK's policies on incident reporting and investigation, available on our Intranet.

HCA UK will also provide guidance on PSIRF policy requirements to provide further clarity for staff on escalation pathways, methods of review, safety action development, safety improvement plans and monitoring improvement.

The aim of this approach to reviewing and responding to incidents is to continually improve, and as such this document will be reviewed annually whilst our confidence in this new approach matures.

It will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a. refocusing PSII towards a systems approach and 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. transferring the emphasis from the quantity to the quality of PSIIs such that it increases confidence in the improvement of patient safety through learning from incidents

d. demonstrating the added value from the above approach.

The aim is for this plan to remain dynamic and flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

Our services

HCA UK is registered with the Care Quality Commission and Health Improvement Scotland to provide its services.

HCA International Ltd, as a service provider, is registered with the Care Quality Commission to carry out the following Regulated Activities:

- Diagnostic and screening procedures
- Family planning services
- Management and supply of blood and blood-derived products
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancy
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder, or injury.

Service Types:

- Acute services
- Blood and transplant services
- Diagnostic and screening services
- Doctor consultation services
- Doctor treatment services
- Remote clinical advice services
- Urgent care services

Health Improvement Scotland:

Service type:

- Independent clinic.

Defining our patient safety incident profile

In reviewing our patient safety insights data and identifying the key patient safety issues to inform this plan we undertook a comprehensive and collaborative review of our patient safety risks and responses from 2019-2022.

The following stakeholders have been involved:

- Our staff – via the incidents reported on HCA UK's Datix incident system
- Thematic review of our patient complaints, claims and coronial reports
- Senior leaders and subject matter experts across the organisation – through a series of stakeholder seminars to sense check our insights data.

HCA UK aims to incorporate a wider patient perspective and input into our future PSIR planning at the next stage of development as we develop our thinking on the introduction of patient safety partners (PSPs), or the equivalent.

HCA UK's patient safety profile was identified through the following data sources:

- Analysis of three years' of Datix incident data 2019-2022
- Detailed thematic analysis of Datix incident data 2022
- Themes from reported Never Events and Serious Incidents
- Key themes from complaints/claims/inquests
- Key themes identified from specialist safety & quality committees (e.g., deteriorating patient; falls; pressure ulcers)
- Output of stakeholder seminar discussions.

National priorities have been defined that HCA UK anticipates will require a response in the next 12 months. Table 1 sets out the full list of national priorities that require a response.

Local patient safety risks have been defined as the list of risks identified through the stakeholder approach and the patient safety data mining described above. These local identified risks represent opportunities for learning and improvement across HCA UK. Table 2 lists our local patient safety priorities.

The criteria HCA UK has used for defining the local patient safety risks is as follows:

A. Potential for harm:
- People: physical, psychological, loss of trust (patients, family, caregivers)
- Service delivery: impact on quality and delivery of healthcare services; impact on capacity and patient flow

B. Likelihood for occurrence:
- Persistence of risk/recurrence
- Frequency
- Potential to escalate.

and the,

C. **Potential for new learning and improvement**.
   - Enhanced knowledge and understanding of the underlying factors
   - Improved efficiency and effectiveness (control potential)
   - Opportunity to influence wider system improvement.

There are many ways to respond to a patient safety incident. This plan covers responses conducted solely for the purpose of system learning and improvement. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

Historically, it has been necessary to investigate each incident report that meets a certain outcome threshold or 'trigger list'. It has since been learnt that, focusing most patient safety investigation efforts on incidents with the most severe outcome does not necessarily provide the most effective route to 'organisational learning'.[1] There has also been found to be no clear need to investigate every incident report to identify the common contributory causes and improvement actions required to reduce the risk of similar incidents occurring

The move to decide which incidents to investigate from a learning and improvement perspective increases the opportunity for continuous improvement by:

a. improving the quality of future PSIIs

b. conducting PSIIs purely from a patient safety perspective

c. reducing the number of PSIIs into the same type of incident

d. aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents.

This approach will allow healthcare organisations to consider the safety issues that are common to similar types of incidents and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

a. being explored and addressed as a priority in current PSII work, or
b. the subject of current improvement work that can be shown to result in progress, or
c. listed for PSII work to be scheduled in the future.

In some cases where a PSII for system learning is not indicated, another response may be required. Options that meet the needs of the situation more appropriately should be considered; please refer to the HCA Incident Management policy.

Responses covered in this plan include:

- Patient Safety Incident Investigations (PSIIs)
- Patient Safety Learning Reviews.

As part of this approach, incidents requiring other types of investigation and decision-making, which lie outside the scope of this plan, will be appropriately referred as follows:

a. professional conduct/competence issues – referred to human resources team

b. establishing liability/avoidability – referred to the legal team

c. medical examiners, and if appropriate, local coroners for issues related to cause of death

d. criminal activity – referred to the police.

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a considered and proportionate approach, informed by our local and national priorities included in our Patient Safety Incident Response Plan (PSIRP). However, our objective is to also facilitate an approach that involves decision making through a multi -professional approach to commission PSII's that maximise opportunity to learn and improve from patient safety incidents. The decision not to undertake a PSII will be agreed on an exception basis only at the PSII 'kick off call.

1. Vincent C, Adams S, Chapman A et al (1999) *A protocol for the investigation and analysis of clinical incidents*.

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 a review by or referral to another body or agency, depending on the nature of the event.

Incidents meeting the Never Events criteria (2018, and subsequent updates) and deaths thought more likely than not to problems in care require a Patient Safety Incident Investigation (PSII).

PSIIs are conducted for system learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

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

Table 1 overleaf sets out the mandated national responses.

Table 1: Mandated National Responses

	Patient Safety Incident Type	Required Reponses
1	Incidents that meet the Never Events criteria	PSII
2	Death clinically assessed as more likely than not use to problems in in care	PSII
3	Maternity and neonatal incidents meeting Every Baby Counts / HSIB criteria	Refer to HSIB for independent PSII
4	Child deaths	Locally led PSII. Must be referred to Child Death Overview Panel
5	Safeguarding incidents in which: • Babies, child, and 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 by their Local Authority • The incident relates to FGM, Prevent • (Radicalisation to terrorism); modern slavery & huma trafficking or domestic abuse / violence.	Refer to named safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (For children) and local Safeguarding Adults Boards
6	Deaths of persons with learning disabilities	Locally led PSII. Refer for Learning Disability Mortality Review (LeDeR).
7	Deaths of patients detained under the Mental Health Ac (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 (incidents meeting the Learning from Deaths criteria)	Locally led PSII by the provider in which the event occurred with HCA UK participation if required
8	Mental Health Related Homicides by persons in receipt mental health services or within six months of their discharge	Locally led PSII may be required with mental health provider as lead and HCA UK participation required
9	Domestic Homicide	A Domestic Homicide is usually identified by the police. If criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a statutory DHR Panel.

Our patient safety incident response plan: local focus

Through analysis of our patient safety insights, potential for learning and improvement, systemic risk, and resources available to complete PSII investigations, HCA UK will investigate each local priority until learning and recommendations have been made and improvement work commenced.

Table 2: Local Priorities for Patient Safety Incident Investigations

Patient safety incident type	Description	Response Type
Deteriorating patients	Unexpected transfers to PICU/ITU/HDU from ward due to delays in recognition of deterioration. This also includes maternity transfers	PSII
Inpatient Falls	Inpatient falls with bone fracture or haemorrhage	Post fall review and PSII
Pressure Ulcers	Device related pressure ulcers in adult and paediatric patients	Pressure Ulcer review and PSII
Medication	Incidents where VTE prophylaxis was missed, omitted, or incorrectly prescribed – adults and paediatrics	PSII
Maternity	Unplanned mother or baby transfer to NHS for ongoing care	PSII
Fertility	Human Fertilisation & Embryology Authority reportable incident: Grade A: involving severe harm to one person, or major harm to many	PSII
Safer surgery	Retained foreign objects (near misses): any disparity in the tally of accountable items, prior to skin closure even if resolved (or found), which would have resulted in further surgery or intervention	PSII
Other	Any emerging unexpected patient safety incident signifying an extreme level of risk and where the potential for new learning and improvement is so great or the consequences of the incident may be significant that it warrants a comprehensive PSII response. Any other patient safety incident with significant opportunity for improvement or learning including near misses.	PSII

Where an incident does not fall into any of the categories above; an investigation and/or review method using learning response tools described in the HCA UK Incident Management Policy may be used by the local team, except PSII (which should not be undertaken by staff who have not received the specialist training required to undertake PSII).

Patient safety improvement plans underway

As PSIRF has a focus on safety improvement a review has also been undertaken of any national, or locally designed patient safety improvement plans underway across HCA UK. This relates to full plans, rather than individual actions, designed and prescribed to address previous PSII, review, audit, or risk assessment findings. These improvement plans will be added to this section as these improvement plans are more formalised and progressed.

Patient Safety Improvement Plan/Scheme	**Detail**
LocSIPPss/NatSIPPs	Using the (2023) NatSSIPs 8 sequential steps to surgical safety (plus Invasive Never Events) develop service line specific LocSSIPs. The checklists will require relevant educational and clinical governance to accompany their use in the clinical workplace. The aim is to build on the positive aspects of the WHO Safer Surgery Checklist acknowledging that checklists alone are not enough to ensure patient safety; a team trained in this area with safe practice at the forefront of their thinking will reinforce best practice and improve patient safety.

Mechanisms to Develop and Support Improvements Following PSIIs:

Our improvement priorities will be directly informed by our patient safety priorities identified from patient safety investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation.

Findings from PSIIs and other learning responses provide key insights and learning opportunities, but they are not the end of the story. Recommendations may be translated into safety actions, which will be detailed on the incident reporting system (DATIX) and reviewed and monitored through Facility Learning and Improvement Panels (LIPs).

If a single response reveals significant risk(s) that require(s) immediate safety actions to improve patient safety, action will be taken as soon as practically possible.

HCA UK are in the process of developing a comprehensive patient safety learning and quality improvement network across the organisation, to bring together colleagues involved in patient safety and improvement to support shared learning and spread any celebration of success.