



PATIENT SAFETY INCIDENT RESPONSE PLAN

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Author/ Reviewer	Dominic Sheehy, Patient Safety Lead		
Plan Sponsor	Jo Howarth, Director of Nursing		
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Patient Safety Incident Response Plan

March 2025

V2 DOM SHEEHY – PATIENT SAFETY LEAD
APPROVED BY PATIENT SAFETY COMMITTEE 17/04/2025
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Executive Summary

The Patient Safety Collaborative (meaning the wider teams) aim to lead on the following;

- Focus thematic reviews of areas of care to align with the Quality Priorities
 - i) **Reducing avoidable** harm to include:
 - hospital acquired pressure ulcers
 - falls prevention & management
 - early recognition and escalation of deteriorating patients
 - ii) **Treatment & procedures** to include:
 - safer administration of insulin
 - delays in transfer of care
 - iii) **Maternity & Neonates** to include:
 - Post natal incidents during admission
 - Post natal incidents requiring readmission
- Create monthly thematic summary of patient safety incidents for escalation to patient safety committee in order to provide assurance that existing priorities are being examined, and that emerging themes are being considered.
- Continue supporting with the pan-Dorset risk management software procurement
- Explore areas for collaboration of patient safety activity across the Dorset federation
- Continue with current Division A/B and Hospital Wide PSIRF Learning Huddles and explore areas for further development aligning with the PSIRF culture.
- Review and grandstand the existing latent patient safety processes that are ongoing within the Trust

- Actively promote the education and use of the range of system-based approaches to learning from PSIs;
 - i) Hot debrief programme of education in place
 - ii) Mandatory training in place via ESR
- Undertake reviews of the quality of patient safety investigations using the national audit tool
- Develop the intranet site for patient safety to include
 - i) Description of the risk reporting pathway and variables
 - ii) Demonstrate the Quality Assurance pathways
 - iii) As a portal for all patient safety documentation, including policies, plans, standard operating procedures, 'how to' guidance
 - iv) To publish learning from patient safety events
 - v) To publish action trackers from the learning from PSIs
 - vi) Re-invest in the Learning From Excellence QI of recent years.
- Explore efficiencies of working in a collaborative model with Dorset HealthCare NHS Foundation Trust, Patient Safety Team.

1. Purpose, scope, aims and objectives

1.1 Purpose

1.1.1 This patient safety incident response plan (PSIRP) sets out how Dorset County Hospital NHS Foundation Trust (DCHFT) will seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care it provides.

1.1.2 This plan will help us measurably improve the efficacy of our response to local patient safety incidents (PSIs) by:

- a. Refocusing review of PSI's towards a systems approach¹ and the rigorous identification of interconnected causal factors and systems issues.
- b. focusing on addressing these causal factors and the use of improvement science² to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- c. transferring the emphasis from the quantity to the quality of incident reviews such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents, but importantly, making changes based on what is discovered
- d. demonstrating the added value from the above approach.

1.2 Scope

1.2.1 A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care. The planning aspects of this PSIRP have been developed with the assistance and approval of our local commissioner(s).

¹ The approach is broken down into units to make it easier to understand the complexity, interactive nature and interdependence of the various external and internal factors.

² "Improvement science is about finding out how to improve and make changes in the most effective way. It is about systematically examining the methods and factors that best work to facilitate quality improvement." Health Foundation (2011) <https://www.health.org.uk/publications/improvement-science>.

The aim of this approach is to continually improve. Our first PSIRP was published in 2024 and was intended to be reviewed after a year. This review has now been completed. Going forward the Trust PSIRP will be formally reviewed on a four yearly basis unless otherwise indicated.

1.2.2 This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

1.2.3 A PSI is defined as;

‘something unexpected or unintended that has happened, or failed to happen, that could have or did lead to patient harm for one or more person(s) receiving healthcare’ (NHS England, 2022).

Some unexpected events may result in identifiable levels of harm, others may be where the potential for harm is identified, so called ‘no harm’ or ‘near miss’ events. An incident is the system showing us symptoms that something can potentially be improved.

1.2.4 There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

1.2.5 Responses covered in this Plan include:

- Hot debriefs
- After Action Reviews (AARs)
- Case Reviews
- Thematic Reviews
- Patient Safety Incident Investigations (PSIIs)
- Medical Examiner Reviews
- Internal professional reviews, including;
 - Mortality and Morbidity Meetings (M&Ms)
 - Structured Judgement Reviews (SJR)

1.2.6 Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this Plan.

1.2.7 To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- human resource (employee relations) teams for professional conduct/competence issues and if appropriate, for referral to professional regulators
- legal teams for clinical negligence claims
- medical examiners, SJRs and, if appropriate, local coroners for issues related to the cause of a death
- the police for concerns about criminal activity

1.3 Strategic aims and objectives

Dorset County Hospital and Dorset HealthCare

Working together, improving lives
Joint strategy 2024-29

NHS

Our vision is for healthier lives, empowered citizens, thriving communities.

Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best.

Our values

Our strategic objectives

- Care**
We provide safe, compassionate care.
 - Improved access to the right care, at the right time, in the right place
 - People are equal partners in their care and have a positive experience
 - Patients and service users are always safe in our care
- Communities**
We help build strong communities where people live well and are healthier.
 - Improved population health and wellbeing through joined up working across health and care
 - People staying well through prevention, detection and early intervention, with more control over their own health
 - People and communities involved in shaping health and care services
- Colleagues**
We are empowered, skilled, caring colleagues who can thrive at work.
 - Colleagues are positive about their experience at work
 - All colleagues feel they belong and are included
 - A sustainable workforce with the right skills now and for the future
- Sustainability**
Our services are sustainable environmentally and financially and we make best use of resources.
 - Releasing time to care through improved processes, skill mix and digitally enhanced technology
 - Sustainable models that optimise use of the available resources
 - Using our size, scale and reach to make a positive difference to the economic and social wellbeing of Dorset
 - Minimise our negative impact on public health and the environment

Dorset County Hospital

- Respect
- Integrity
- Teamwork
- Excellence

Dorset HealthCare

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts
- Commitment to learning

1.3.1 In order to meet the strategic aims we will;

- Demonstrate a climate that supports a just culture and an effective learning response to patient safety incidents.
- Aggregate and confirm validity of learning and improvements by basing patient safety reviews on a number of similar repeated incidents.
- Develop system improvement plans based on the learning from patient safety reviews
- Support, involve and act on feedback from patients, families, carers, and staff with regard to patient safety incident responses.
- Focus on the quality rather than the quantity of reviews in order to learn from and develop meaningful actions in response to patient safety events.

2. Situational analysis – national

- 2.1 The patient safety incident response framework (PSIRF) promotes an approach of reviewing patient safety incidents from a learning and improvement perspective.
- 2.2 We need to remove the barriers in healthcare that have frustrated the success of learning and improvement following a patient safety incident (e.g., mixed investigation remits, lack of dedicated time, limited investigation skills). We also need to increase the opportunity for continuous improvement by:
 - a. improving the quality of future safety reviews
 - b. conducting reviews purely from a patient safety perspective
 - c. reducing the number of reviews into the same type of incident
 - d. aggregating and confirming the validity of learning and improvements by basing reviews on a small number of similar repeat incidents.
- 2.3 This approach will allow us 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 patient safety work or
 - b. the subject of current improvement work that can be shown to result in progress or
 - c. listed for safety work to be scheduled in the future.
- 2.4 There are a variety of options that can be considered for review of patient safety events, depending on the specific circumstances of the safety event(s); these are listed in Section 5.
- 2.5 As part of this approach, incidents requiring other types of investigation and decision-making, which lie **outside the scope** of this work, will be appropriately led by other partner agencies as follows:
 - professional conduct/competence – referred to human resource teams.
 - establishing liability/avoidability – referred to claims or legal teams.
 - cause of death – referred to the coroner's office.

- criminal – referred to the police.

3. Situational analysis – local

3.1 Results of a review of activity and resources

3.1.1 Situational Analysis of Resources

A review of the Trust's local system was undertaken to understand the systems and people involved in patient safety activities across DCH, as well as the underpinning structure.

Within DCH, the central Patient Safety Team works alongside the Risk Management, Patient Experience & Public Engagement and Clinical Effectiveness Teams within the Nursing and Quality directorate.

The majority of patient safety responses happen at a very local level, through the individual care groups, with oversight from the Divisional Directorates.

Other activities within the Trust that provide insight into patient safety include our incident reporting system, Structured Judgment Reviews (SJR), Learning from Deaths reports, complaints, patient and family feedback and inquest responses.

3.1.2. Situational Analysis of Patient Safety Activity

A review of patient safety incidents undertaken from April 2024 to March 2025, to understand the amount of patient safety activity ongoing (appendix 1). Patient safety activity is reviewed to dynamically inform this plan so that priorities can be amended in the light of current evidence of patient safety risk, which we would expect to alter in response to changing activity, and as a result of quality improvements.

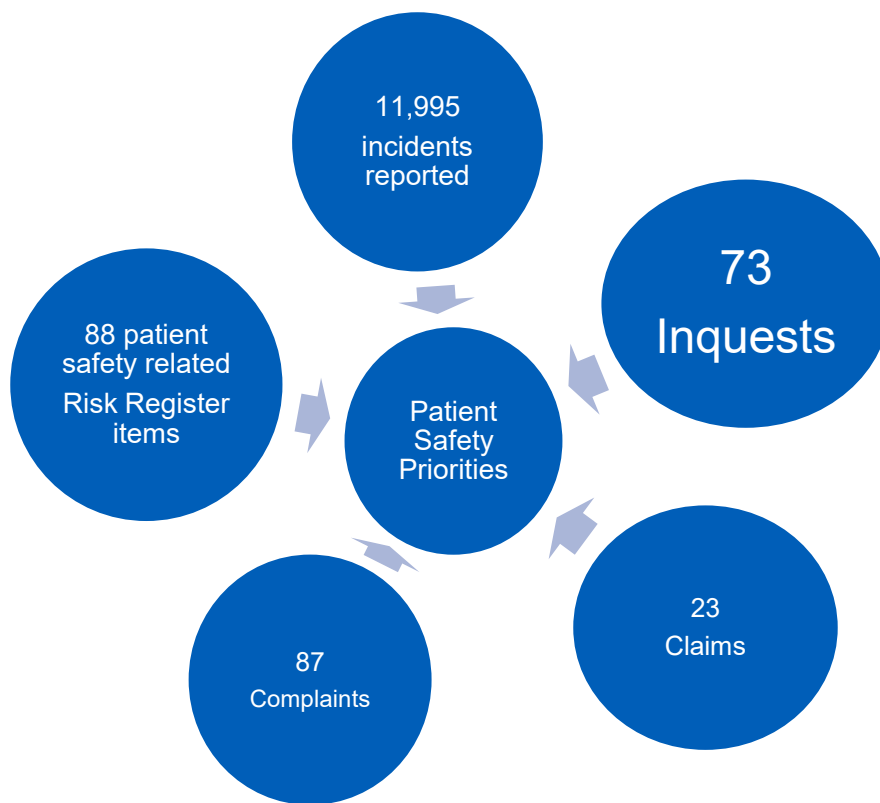
3.2 Patient Safety Incident Risks

3.2.1. The patient safety incident risks for this organisation have been profiled using organisational data from recent patient safety incident reports, complaints, mortality reviews, case note reviews, staff survey results, claims.

Resources examined for this data include:

- staff survey explorer tool results:
 - <https://dchftnhs.sharepoint.com/sites/HR/SitePages/Staff-Survey.aspx>
 - Datix risk management database (patient safety incidents, SJR's and complaints)
 - Claims database – locally held
 - Coroners database – locally held

Review of the local patient safety incident profile



3.3.1 The current top 10 local priorities for patient safety investigation were selected through gap analysis and stakeholder approval utilizing the number of types of incident and themes from those areas outlined in 3.2.1.

The top 10 incidents (no harm to severe) include:

Incident Type		Most Common Sub-causal factor	
1	Patient Tissue Viability/Pressure Ulcer/Skin Damage	Acquired Pressure Ulcer (Pressure areas on arrival excluded)	2100
2	Patient Slip, trip or fall	Fall or slip from standing	894
3	Medicines	Administration: Missed or delayed medication	1056
4	Patient Care - Treatment and Procedure	Delay or failure to monitor a patient (Including deteriorating patient specific)	1012
5	Admission, Transfer and Discharge	Discharge delay or failure to discharge	764
6	Maternity and Neonatal	All events	578
7	Documentation Management	Missing or inadequate or illegible healthcare record	388
8	Staffing/Workforce Capacity	Unfilled bank or agency staff request	415
9	Aggression, violence, theft and security	Non-physical assault (inc verbal) Patient/other to Employee/other	556
10	Communication and Consent	Communication failure – outside of immediate team	1056

The top 6 themes form the basis of our patient safety priorities as the remaining areas are being covered by other programs of work.

3.3.2 Findings from the Staff Survey 2023-2024

The Staff survey asked for agreement rating of specific questions around the Trust’s management of patient safety responses; The available responses were categorised as;

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

The questions posed were;

- My organisation treats staff who are involved in an error, near miss or incident fairly.
- My organisation encourages us to report errors, near misses or incidents.
- When errors, near misses or incidents are reported, my organization takes action to ensure that they do not happen again.
- We are given feedback about changes made in response to reported errors, near misses and incidents.
- I would feel secure raising concerns about unsafe clinical practice.
- I am confident that my organization would address my concern.

In terms of staff responses, it is encouraging that the majority of staff veered broadly towards agreeing with the statements. However, it must also be noted that a significant proportion of staff (on aggregate) expressed ambivalence or overt disagreement with the statements. (See Appendix II).

There was a significant majority of staff respondents who felt the organisation encourages reporting. Conversely there was a significantly aggregated proportion of staff who felt that feedback was lacking after events were reported. The majority of staff felt secure in reporting incidents, however, psychological safety is a major foundation of PSIRF, and we cannot underestimate the importance of raising the profile of a safe environment for reporting, to encourage those who do not yet have that confidence.

For significant numbers of staff to feel they may not be treated fairly when reporting/being involved in an incident, feeling that the organization does not fully encourage reporting, that the organization does not take action or give feedback regarding the response, and that they would not feel confident or secure that the response would be appropriate, gives significant weight to the argument that the tenets of PSIRF are not entirely embedded into the culture of reporting across DCH. This will be included in the actions going forward.

3.4 Gap analysis

3.4.1 Referral to the [national PSII standards](#) to identify gaps in dedicated PSII personnel, seniority, PSII skills, etc. to enable delivery of the potential PSII programme; that is:

- a. National priorities:
 - Never Events

- 'Learning from Deaths' - related incidents (identified via structured judgement review to be more likely than not due to problems in care)
 - unexpected incidents which signify an extreme level of risk for the patients, families and carers, staff or organisations, and where the potential for learning and improvement is so great (within or across a healthcare service/pathway) that they warrant the use of additional resources to mount a comprehensive PSII response.
- b. Local priorities identified in 3.3.1 above.
- c. Excluding incident types that are already part of an active improvement plan that is being monitored to determine efficacy and for which incremental improvement can be demonstrated.

3.5 Strategic plan

3.5.1 National guidance recommends that 3-6 PSII investigations per priority are conducted per year. When combined with patient safety incident investigations from the national priorities this will likely result in 20-25 investigations per year. At DCH we do not have the personnel capacity to manage a planned workload of this magnitude. We continue to utilise a pragmatic approach to selection of incidents/themes for PSII as described below.

3.5.2 The following will need to be in place as part of the process for managing investigations under the PSIRF framework.

- a. Acknowledge that, wherever available, review findings and analysis from more than one similar incident provides an opportunity to identify common causal factors by cross-referencing and corroborating them. Robust thematic analysis can be achieved by selecting a few very recent and typically similar incidents and investigating each one individually with skill and detail to determine the causal factors so that effective improvements can be designed to address change. Review/investigation of recent rather than historical incidents allows information gathering and analysis of the system as it currently is.
- b. Agree the PSII to be conducted for each very themed cluster of safety events, depending on emerging themes.
- c. Remove the need to declare the number of each of these incident types and the total number of PSII planned for the period of the plan, and take

the approach of carrying out PSII's according to need and in agreement with the Executive team

- d. Agree interventions for incidents that fall outside the incident review plan but require action or new insight, e.g.:
 - incident report or timelines (for Duty of Candour disclosure)
 - audit (to measure/ monitor compliance against policy/ guidance)
 - HR investigations (for concerns about individual competency/ performance)

3.5.3 For each comprehensive PSII:

- a. Ensure each PSII is conducted separately, in full and to a high standard, by a team whose lead investigator is an experienced Band 8 and has received a minimum of two days' training.
- b. Refer to training and the [national PSII standards](#) and conduct PSII's as per the plan and in line with national good practice for PSII.
- c. Use the national standard template to report the findings of the PSII's.
- d. Identify common, interconnected, deep-seated causal factors (not high-level themes or problems).

3.5.4 For each group of incident reviews dedicated to a similar/narrow focus incident type:

- a. Design strong/effective improvements to sustainably address common interconnected causal factors.
- b. Develop an action plan for implementation of the planned improvements.
- c. Monitor implementation of the improvements.
- d. Monitor effectiveness of the improvements over time.

3.5.5 Monitor the quality of incident review findings and progress against this PSIRP using the national tool.

4. Selection of incidents for patient safety incident investigation

4.1 Aim of a patient safety incident investigation (PSII)

4.1.1 PSII are conducted for systems 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.

4.2 Selection of patient safety incidents for PSII

4.2.1 In view of the above, the selection of incidents for PSII is based on the:

- a. actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds, etc.)
- 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).
 - opportunity to influence wider system improvement.

Evidence of emerging themes provided by the patient safety/risk team on a monthly basis and reported to the Patient Safety Committee.

4.3 Timescales for patient safety PSII

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

4.3.2 PSII should ordinarily be completed within one to three months of their start date.

4.3.3 In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between us and the patient/family/carer.

4.3.4 No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, 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. (Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.)

4.4 Nationally defined priorities to be referred for PSII or review by another team

4.4.1 The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) are:

a. **maternity and neonatal incidents:**

- incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred for Maternity and Newborn Safety Investigation (MNSI). ([Home \(mnsi.org.uk\)](http://mnsi.org.uk))
- all cases of severe brain injury must also be referred to NHS Resolution's [Early Notification Scheme](#)
- all perinatal and maternal deaths must be referred to [MBRRACE](#)

b. **mental health-related homicides by persons in receipt of mental health services or within six months of their discharge** must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

c. **child deaths** ([Child death review statutory and operational guidance](#)):

- incidents must be referred to child death panels for investigation

d. **deaths of persons with learning disabilities:**

- incidents must be reported and reviewed in line with the [Learning Disabilities Mortality Review \(LeDeR\) programme](#)

e. **safeguarding incidents:**

- incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multiprofessional investigation
- f. **incidents in screening programmes:**
- incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)
- g. **deaths of patients in custody, in prison or on probation** where healthcare is/was NHS funded and delivered through an NHS contract:
- incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

4.5 Nationally defined incidents requiring local PSII

4.5.1 Nationally defined incidents for local PSII are set by the PSIRF and other national initiatives. These are:

- a. **incidents that meet the criteria set in the [Never Events list 2018](#)**
- b. **incidents that meet the ['Learning from Deaths' criteria](#)**; that is, deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local Learning from Deaths plan, or following reported concerns about care or service delivery. Further, specific examples of deaths where a PSII must take place include:
- i. **deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's [mortality review tool](#)** and which have been determined by case record review to be more likely than not due to problems in care.
 - ii. **deaths of persons 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 healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review

- iii. **deaths of patients in custody, in prison or on probation** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS
- c. suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.

4.6 Locally defined incidents requiring local PSII

4.6.1 Based on the local situational analysis and review of the local incident reporting profile, local priorities for PSII have been set by this organisation.

- a. **Locally-defined emergent patient safety incidents requiring PSII.** An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.
- b. **Locally predefined patient safety incidents requiring investigation.** Key patient safety incidents for PSII have been identified by this organisation (through analysis of local data and intelligence from the past three years), and will be agreed with the commissioning organisation as a local priority in line with the following guidance:
 - **Criteria for selection of incidents for PSII:**
 - 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)
 - c. potential for learning in terms of:
 - enhanced knowledge and understanding
 - improved efficiency and effectiveness (control potential)
 - opportunity for influence on wider systems improvement.

A number of incident types such as in-patient falls, and development/deterioration of pressure damage have active improvement delivery plans in place, based on learning identified from previous patient safety incident investigations. Delivery of these improvement plans will be monitored by the central patient safety team and via their respective specialist subgroup. A

combination of both process and outcome metrics will be utilised to measure their effectiveness once fully complete.

4.7 Thematic analysis following the completion of a small number of individual investigations of similar patient safety incidents

4.7.1 A valuable and thorough way of accomplishing thematic analysis of patient safety incident findings is to select a few (three to six) recent and very similar incidents and **investigate each individually** with skill and rigour to determine the interconnected contributory and causal factors.

4.7.2 The findings from each individual investigation are then collated, compared and contrasted to identify common **causal factors** and any common interconnections or associations upon which effective improvements can be designed.

4.7.3 Importantly, investigation of recent incidents allows more accurate information gathering from properly specified, good quality PSIs, and detailed analysis of the system as it currently stands.

4.8 Patient safety improvement plans underway

4.8.1 DCH will continue to review existing processes and governance pathways, to build upon and share existing good practice which already aligns with the principles outlined in the national PSIRF. We will compare our progress against the national PSIRF standards to highlight where we are meeting the requirements and where we can focus our efforts towards meeting these standards ongoing.

4.8.2 Ongoing patient safety improvement plans developed in response to our identified priorities are detailed below:

	Local patient safety incident improvement plans	Specialty	Monitoring forum
Reducing avoidable harm			
1	Hospital acquired pressure Ulcers	Trust wide	Patient Safety Committee
2	Falls prevention & management	Trust wide	Patient Safety Committee
3	Early recognition and escalation of deteriorating patients	Trust wide	Patient Safety Committee
Treatment & procedures			
4	Safer administration of insulin	Trust wide	Patient Safety Committee
5	Delays in transfers of care	Trust wide	Strategy & Transformation
Maternity and Neonates			
6	Post natal incidents during admission	Maternity & Neonates	Divisional Governance & Patient Safety Committee
7	Post natal incidents requiring admission	Maternity & Neonates	Divisional Governance & Patient Safety Committee

5. Working with Patients and Families.

- 5.1 The PSIRF recognises that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. The PSIRF supports development of a patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents.
- 5.2 Patients and families should be given every opportunity to be involved at every step and have the process explained to them. Involvement should be flexible and adapt to changing needs as each situation will be different. The Trust will apply the following principles when working with patients and families:
- 5.3 Communication should be a two-way dialogue to allow the imparting and receipt of helpful and accurate information. The use of plain language and avoiding jargon or acronyms will aid understanding. Where appropriate, checking understanding and summarising can ensure the intended message has been received and is understood.
- 5.4 Good communication must continue throughout any patient safety review, providing updates where appropriate and as agreed with those affected.
- 5.5 Resources for engaging and working with families are available at learn-together.org.uk – Serious Incident Investigation resources and these should be read alongside the Trust: [Being Open and Duty of Candour Policy \(Ref 0979\)](#)
- 5.6 Families and staff may need to be signposted to support at any point during engagement or involvement in a learning response. Our process should ensure there is equity in the support offered to families and staff, and that systems exist for internal and external support so that those affected can access support in the way they prefer, wherever possible.
- 5.7 Engagement and level of involvement must be in keeping with the wishes of those affected as far as possible.
- 5.8 We will use the overarching framework described below as a guide in building systems and processes in collaboration with patient partners and/or those with lived experience.

5.8.1 Not all steps may be required, some steps may need to be repeated and the process may not be as linear as implied. The DCH approach must be adapted to meet the circumstances of each patient safety incident and the individuals affected.



6. Selection of incidents for review

6.1 Different review techniques can be adopted, depending on the intended aim and required outcome. The most commonly used are:

Technique	Method	Objective
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent: <ol style="list-style-type: none"> discomfort, injury, or threat to life damage to equipment or the environment.
<u>'Being open' conversations</u>	Open disclosure	To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
<u>Case record/notes review</u>	Clinical documentation review	To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)
Hot debrief	Debriefing	To conduct a post-incident review as a team by discussing and answering a series of questions.
<u>Safety huddle</u>	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: <ul style="list-style-type: none"> improve situational awareness of safety concerns. focus on the patients most at risk. share understanding of the day's focus and priorities. agree actions. enhance teamwork through communication and collaborative problem-solving. celebrate success in reducing harm.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a <u>'chronology'</u> .
<u>After-action review</u>	Team review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely.
LeDeR (Learning Disabilities Mortality Review)	Specialist Review	<u>To review the care of a person with a learning disability</u> (recommended alongside a case note review).

Technique	Method	Objective
<u>Perinatal mortality review tool</u>	Specialist review	Systematic, multidisciplinary, high-quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
Mortality review	Specialist Review	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
<u>Clinical audit</u>	Outcome audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes.
<u>Risk assessment</u>	Proactive hazard identification and risk analysis	To determine the likelihood of an identified risk and its potential severity (e.g., clinical, safety, business).

6.2 Priorities for ‘being open’ conversations and Duty of Candor include:

- all patient safety incidents leading to moderate harm or above (Duty of Candor)
- all incidents for which an investigation is undertaken. (Being Open)

7 Roles and responsibilities

7.1 DCH has held a series of workshops to clearly identify the investigation processes and at what level of staff need to be involved at each stage. This work aims to clearly describe roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

7.1.1 The Trust will be looking to align its processes with the other local NHS Providers, as many patients have a number of services involved within their care. It is acknowledged that using common language and templates will assist with the investigation process.

7.2 Training

7.2.1 The Patient Safety Strategy includes a patient safety syllabus which is accessible via the elearning for health portal, augmented by externally provided training as detailed below. The Patient Safety Team will deliver trust wide training for staff focusing on the appropriate use of incident review tools (see section 6.1). Training compliance is reported through the Patient Safety Committee.

Topic	Provider	All staff	Clinical Staff	Learning response leads/managers	PSRIF lead roles	Oversight roles
National Patient Safety Level 1: Essentials for Patient Safety	eLearning for health	✓	✓	✓	✓	✓
National Patient Safety Level 2: Access to Practice	eLearning for health		✓	✓	✓	✓
Involving those affected by	External Provider			✓	✓	

Patient Safety Incidents						
Approach to Patient Safety Reviews	3 day course – external provider			✓	✓	
Systems approach to learning from Patient Safety Incidents	External provider				✓	
Oversight of Learning from Patient Safety Incidents	External provider					✓

8. Evaluating and monitoring outcome, Reviews/Investigations

- 8.1 Robust findings from reviews provide key insights and learning opportunities, but they are not the end of the story.
- 8.2 Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIRs.
- 8.3 Improvement work should only be shared once it has been tested and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents, in line with quality improvement methodology.
- 8.4 Regular reports to the Board will include aggregated data on:
 - patient safety incident reporting
 - audit and review findings
 - findings from safety reviews
 - progress against the PSIRP
 - results from monitoring of improvement plans from an implementation and an efficacy point of view.
 - results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
 - results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.

	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total
Admission, Transfer and Discharge	54	72	65	64	55	41	65	55	92	59	59	83	764
Communication and Consent	14	27	16	28	20	29	25	18	19	29	18	25	268
Diagnostic imaging management	1	4	4	6	5	2	7	9	5	6	9	9	67
Documentation Management	26	30	31	28	38	34	30	49	23	31	39	29	388
DOLS	1	0	1	1	1	0	0	2	0	0	0	2	8
Estates and Facilities Incident	149	76	96	154	167	76	99	63	38	21	22	15	976
Final Fate Blood products	5	3	2	5	2	0	3	2	1	6	2	5	36
Fire Safety Incidents	0	2	4	4	1	0	0	2	3	2	3	2	23
Infection Prevention	13	6	13	15	13	20	25	11	13	12	14	12	167
Information Governance and Breach of Confidentiality	14	13	16	30	15	16	18	23	12	18	28	19	222
Inoculation injury	4	5	6	8	4	7	4	5	6	10	7	6	72
Major Trauma	0	0	0	0	0	0	0	0	0	0	0	2	2
Maternity and Neonatal	46	41	47	41	56	60	49	53	39	55	39	52	578
Medical Devices	15	14	15	23	11	23	17	34	22	37	22	26	259
Medicines	75	92	96	82	98	86	84	94	83	107	76	83	1056
Mixed sex accommodation	23	23	29	25	14	15	22	9	22	9	5	15	211
Mortuary Quality Management	0	0	1	0	0	1	0	0	4	1	0	0	7
Non Medical Devices	20	10	10	10	10	12	14	14	13	12	13	8	146
Other type of incident	1	1	2	2	0	0	4	3	6	3	1	2	25
Partner Agency Incident	54	61	38	86	85	74	82	61	53	42	42	47	725
Pathology Management	5	16	17	11	19	19	14	14	15	24	13	17	184
Patient Care - Deteriorating Patient Care	4	4	3	8	10	7	9	8	6	3	2	6	70
Patient Care - Treatment and Procedure	87	85	77	94	56	78	84	75	73	67	81	85	942
Patient Slip, trip or fall	77	68	62	72	62	87	66	68	84	77	73	98	894

Patient Tissue Viability/Pressure Ulcer/Skin Damage	133	191	187	186	182	160	187	175	188	207	149	155	2100
Privacy, Dignity and Diversity	8	1	7	2	1	6	1	2	3	3	2	1	37
Radiation incidents involving ionising radiation	3	7	7	4	4	2	2	2	10	2	4	1	48
Rejected/Duplicated Incident	0	1	0	0	0	0	0	0	1	1	0	0	3
Resuscitation 2222 call out and End of Life	3	5	7	6	14	7	7	9	8	4	4	5	79
Safeguarding Adult Concern	1	1	1	4	1	1	2	1	3	2	1	3	21
Safeguarding Child Concern	1	0	0	0	0	0	2	0	0	1	0	0	4
Staffing/Workforce Capacity	43	29	19	19	31	30	67	29	24	37	36	51	415
Sterile Services Department (SSD)	2	1	13	8	8	6	4	3	5	8	6	10	74
Transfusion incident	8	3	4	3	2	5	8	3	4	3	7	4	54
Violence, Aggressive, Property offences and Security events	30	51	43	55	46	41	73	58	34	43	37	45	556
Incident accident	13	12	18	15	24	19	17	22	18	21	12	23	214
Mental Health	2	1	1	3	3	4	3	3	2	0	2	3	27
Structure Judgement Review (SJR)	49	27	13	29	8	44	4	23	22	5	36	13	273
Total	984	983	971	1131	1066	1012	1098	1002	954	968	864	962	11995

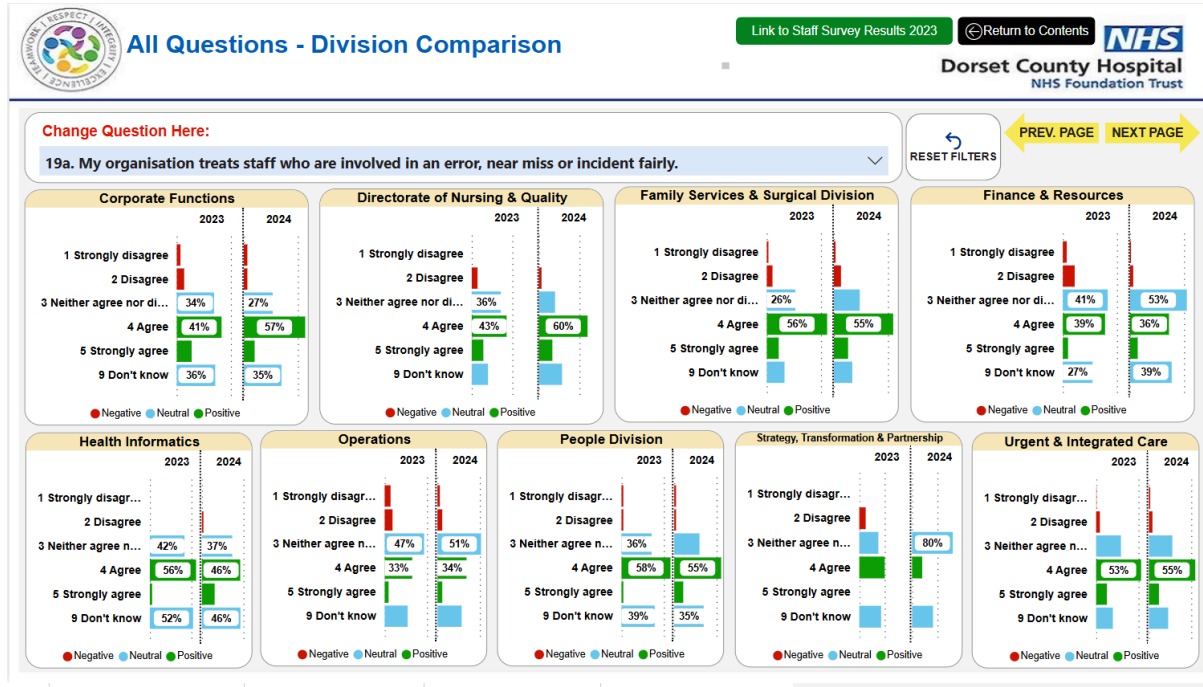
Appendix 1

Incidents recorded on local risk management system, by frequency, 01 April 2024-31 March 2025

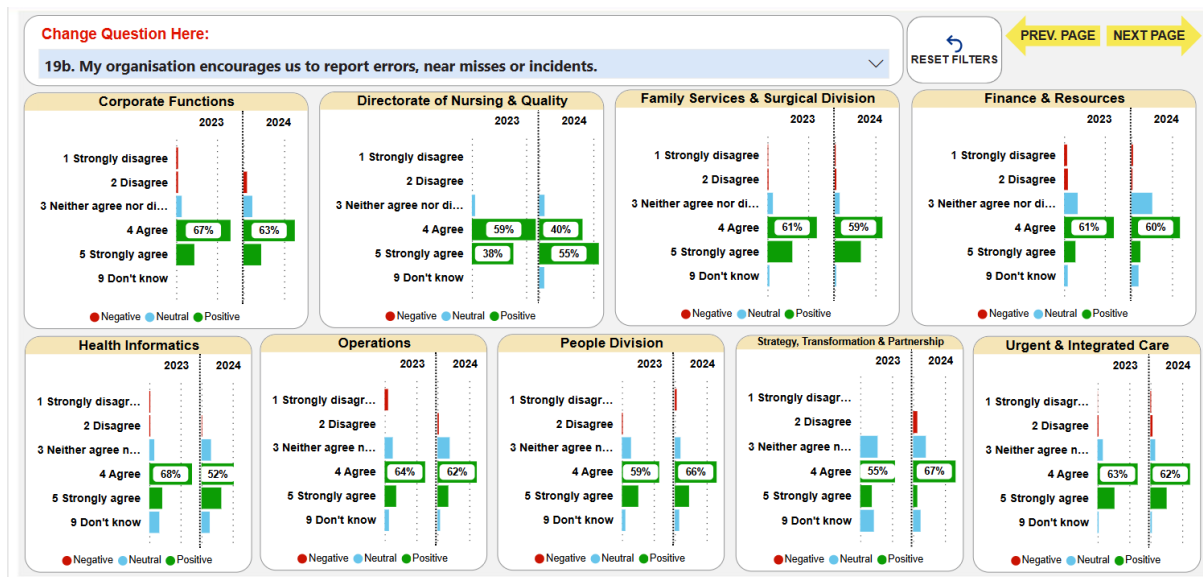
Appendix II

Summary Results from DCH Staff Survey 2023-2024

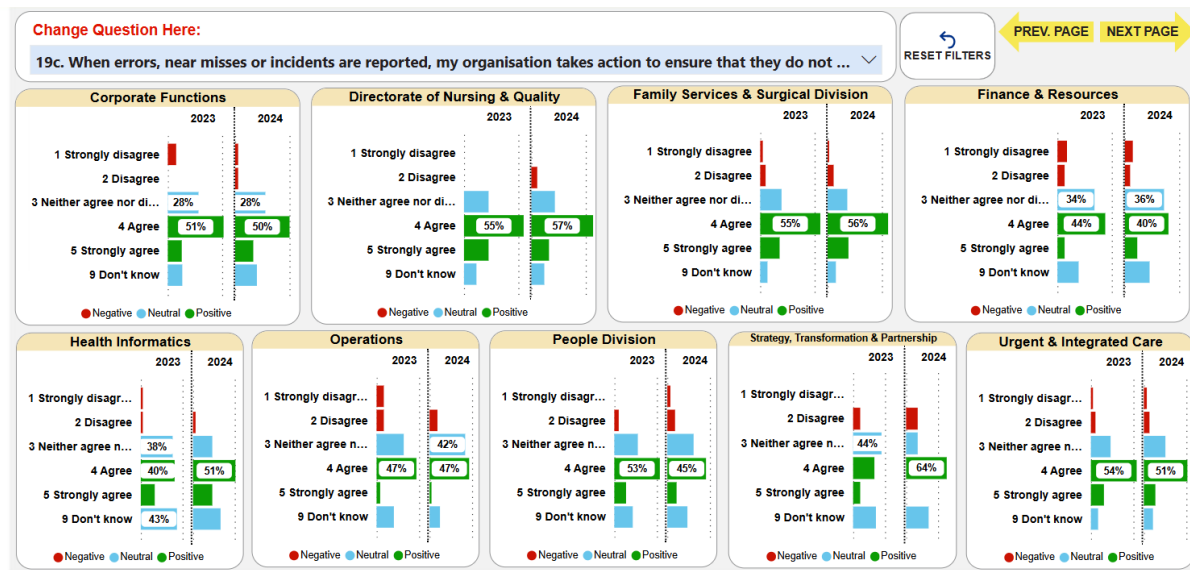
My organisation treats staff who are involved in an error, near miss or incident fairly.



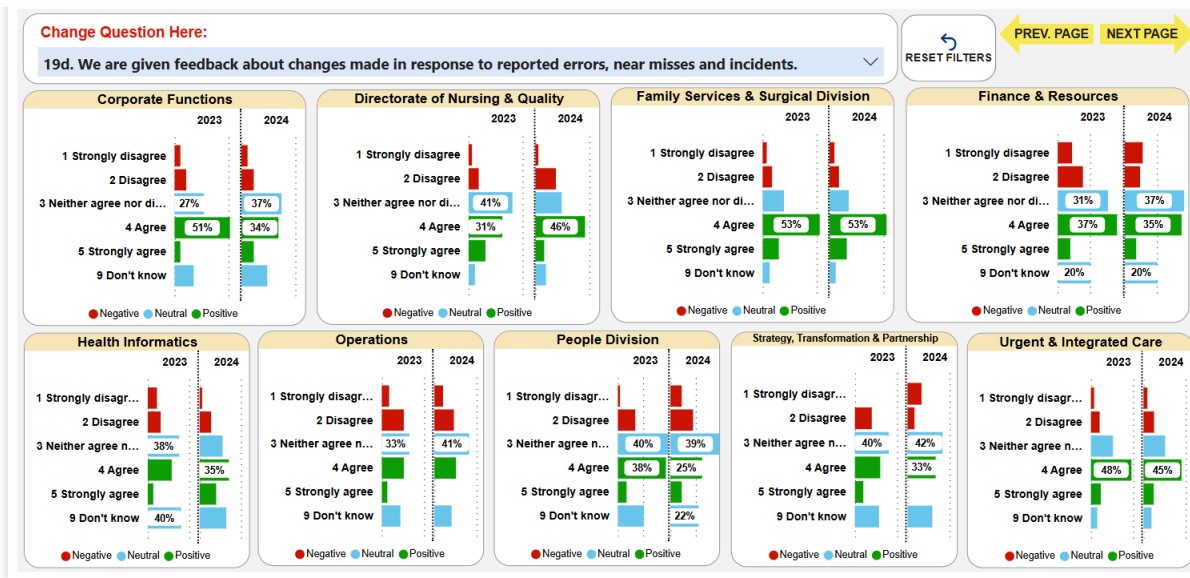
My organisation encourages us to report error, near misses or incidents.



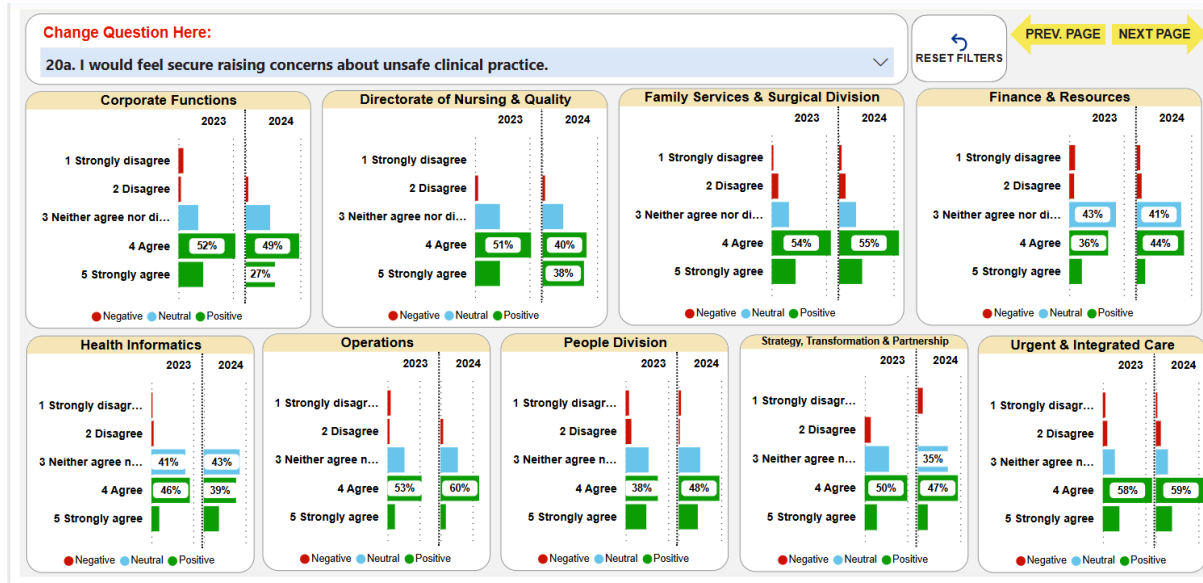
When error, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



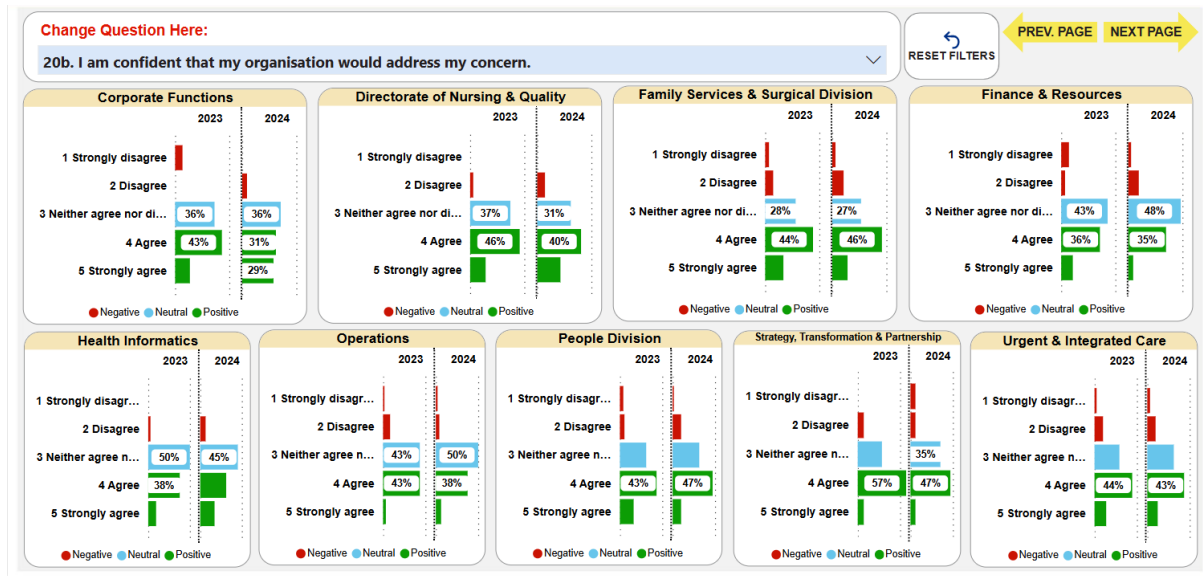
We are given feedback about changes made in response to reported errors, near misses and incidents.



I would feel secure raising concerns about unsafe clinical practice.



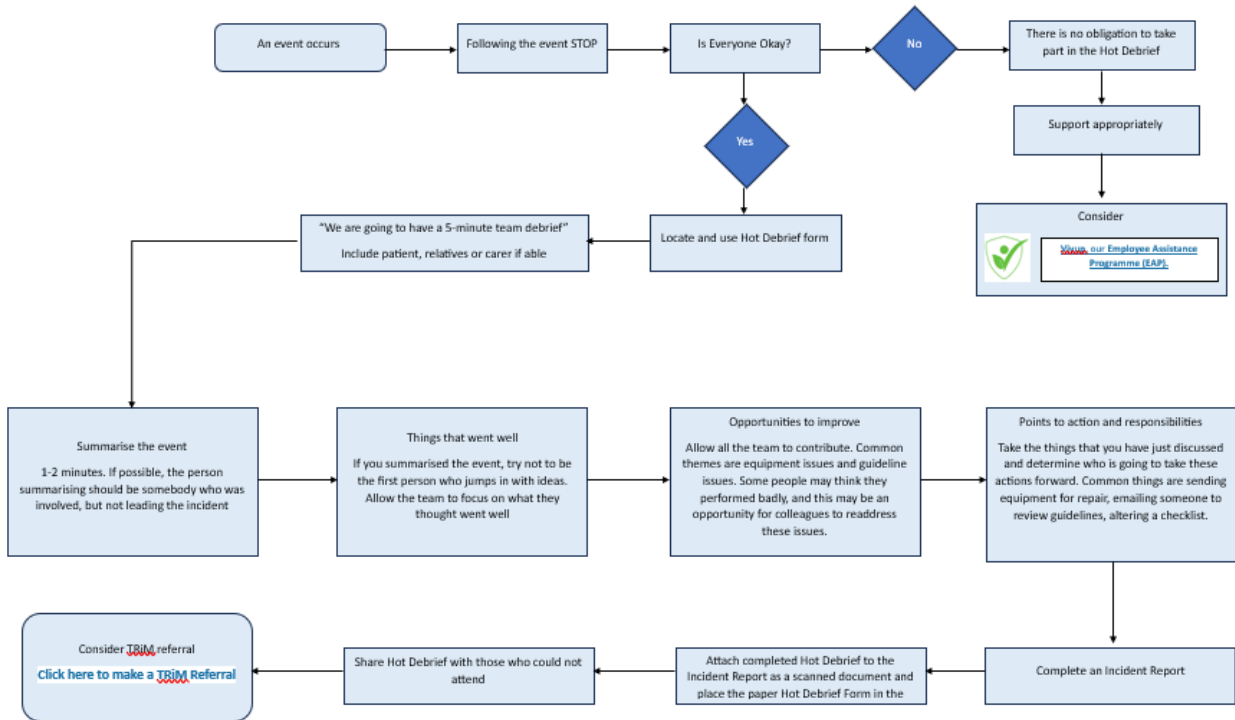
I am confident that my organisation would address my concern.



Appendix III

Hot Debrief SoP Flowchart

PSIRF Standard Operating Procedure: HOT Debrief



Appendix IV

After Action Review SoP Flowchart

