

**Patient Safety Incident Response Policy**

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| **Policy Reference Number:** | CORP-QUA-POL-8 |
| **Version Number:** | 2.1 |
| **Approving Committee/Group** | Trust Management Board |
| **Department / Category** | Quality & Patient Safety |
| **Accountable Executive Lead** | Chief Nursing Officer |
| **Author’s Job title** | Head of Patient Safety Improvement |
| **Brief Outline of This Policy and Standard Operating Procedure** | This policy is a replacement for previous incident management policies. It aligns to the new national Patient Safety Incident Response Framework (PSIRF). |

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| **Date Approved** | 01 November 2024 |
| **Approved By** | Patient Safety Group |
| **Date Ratified** | 01 November 2024 |
| **Ratified By** | Patient Safety Group |
| **Published Date**  **(made live for use)** | 06 November 2024 |
| **Review Date** | 06 November 2027 |
| **Target Audience** | All staff |

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| **Key Principles of This Policy** | |
|  | Compassionate engagement and involvement of those affected by patient safety incidents |
|  | Application of a range of system-based approaches to learning from patient safety incidents |
|  | Considered and proportionate responses to patient safety incidents |
|  | Supportive oversight focused on strengthening response system functioning and improvement |

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| **Document Control/History List** | | | |
| **Version No** | **Date** | **Author’s Job Title** | **Reason and Summary of Change** |
| 1 | 17.01.24 | Head of Patient Safety Improvement | Policy for staff guidance |
| 2 | 15.05.24 | Director of Quality, Integrated Governance & Patient Safety | Slight amendment to section ‘Incidents subject to a complaint or claim’ on Page 38. Removal for the need for an AAR following every inquest |
| 2.1 | 01.11.24 | Head of Patient Safety Improvement | Additional guidance notes added to appendix 2 |

**POLICY ON A PAGE**

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| 1. **Why do we need this Policy** |
| This document is to provide guidance to staff within Medway NHS Foundation Trust (MFT), about the process and responsibilities, for reporting, investigating and learning from incidents.  MFT aims to analyse all incidents, and near misses, along with all identified good practice to ensure that we are striving to learn and improve internally on a continual basis. |

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| 1. **What do I need to know** | 1. **Quality Standards** |
| * It is the responsibility of all staff to report near misses and incidents across the organisation. * All incidents will be reviewed and identified for an appropriate learning response. * The Trust will analyse patient safety data for emerging themes and trends and take relevant action to improve the safety for its patients, staff and visitors. | * Patient Safety Incident Response Framework (PSIRF) * CQC Safe Domain |
| 1. **Understanding the Process** | 1. **Contact** |
| * Incident reported * Incident validated * Level of further investigation determined * Investigation commenced * Investigation completed * Learning shared | Patient Safety Team  [medwayft.patientsafetyteam@nhs.net](mailto:medwayft.patientsafetyteam@nhs.net)  Patient Safety Improvement Team  [medwayft.patientsafetyimprovementteam@nhs.net](mailto:medwayft.patientsafetyimprovementteam@nhs.net)  Deputy Director for Quality and Patient Safety  [wayne.blowers@nhs.net](mailto:wayne.blowers@nhs.net) |

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## Purpose

This policy sets out **Medway NHS Foundation Trust’s** approach to patient safety incident management across the organisation.

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out **Medway NHS Foundation Trust’s** approach to developing and maintaining effective systems and processes for responding to incidents and issues for the purpose of learning and improving patient, staff and visitor safety.

This policy is split into four Key sections:

* Reporting incidents
* Patient Safety incidents
* Other incidents (with references to additional policies for specific incident management across the organisation such as fire, health and safety etc.)
* Post incident guidance

All sections follow the same fundamental principles based around the PSIRF.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports the development and maintenance of an effective incident response system that integrates the four key aims of the PSIRF:

* compassionate engagement and involvement of those affected by patient safety incidents
* application of a range of system-based approaches to learning from patient safety incidents
* considered and proportionate responses to patient safety incidents and safety issues
* supportive oversight focused on strengthening response system functioning and improvement.

## Scope

This policy is specific to incident responses conducted solely for the purpose of learning and improvement across all services provided by Medway NHS Foundation Trust. Other responses are referenced within the document.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error’, are stated as the cause of an incident.

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. We recognise that even a ‘*simple’* error such as the administration of the wrong drug will often have many complex systemic causes, and it is increasingly recognised in healthcare that such systemic problems cannot simply be addressed by local initiatives. Therefore, it is key to have an approach which drives learning and improvement at scale whilst remaining compassionate and supportive to those harmed. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

This document provides the framework for the management of incidents, which all members of staff and contractors working on our premises and contracts, including staff on interim or honorary contracts and volunteers must follow if they occur on Trust property or as a result of any work activity conducted by or on behalf of the Trust. It is accompanied by a corresponding SOP to provide guidance on how to comply with this policy.

## Definitions

| **Terminology** | **Definition** |
| --- | --- |
| **Immediate safety actions** | To take urgent measures to address serious and imminent:   1. discomfort, injury, or threat to life 2. damage to equipment or the environment. |
| **‘**[**Being open’**](https://webarchive.nationalarchives.gov.uk/20171030124348/http:/www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/) **conversations** | 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. |
| [**Case record/note review**](https://improvementacademy.org/documents/Projects/avoidable_mortality/Case%20Note%20Review%20Guide%20FULL.pdf) | 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** | To conduct a post-incident review as a team by discussing and answering a series of questions. |
| [**Safety huddle**](https://www.england.nhs.uk/atlas_case_study/improving-patient-safety-by-introducing-a-daily-emergency-call-safety-huddle/) | A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to:   * 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** | To provide a detailed documentary account of an incident (what happened) in the style of a ‘[chronology’](https://study.com/academy/lesson/what-is-chronological-order-definition-example.html). |
| [**After-action review**](https://improvement.nhs.uk/documents/2087/after-action-review.pdf) | 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. |
| **SWARM** | 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. Swarms enable insights and reflections to be quickly sought and generate prompt learning. |
| **LeDeR (Learning Disabilities Mortality Review)** | [To review the care of a person with a learning disability](http://www.bristol.ac.uk/sps/leder/) (recommended alongside a case note review). |
| [**Perinatal mortality review tool**](https://www.npeu.ox.ac.uk/mbrrace-uk/pmrt) | 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** | 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. |
| **Transaction audit** | To check a trail of activity through a department, etc, from input to output. |
| **Process audit** | To determine whether the activities, resources and behaviours that lead to results are being managed efficiently and effectively, as expected/intended |
| **Outcome audit** | To systematically determine the outcome of an intervention and whether this was as expected/intended |
| [**Clinical audit**](https://www.hqip.org.uk/wp-content/uploads/2018/02/developing-clinical-audit-patient-panels.pdf) | 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. |
| [**Risk assessment**](http://www.mtpinnacle.com/pdfs/Healthcare_Risk_Assess.pdf) | To determine the likelihood of an identified risk and its potential severity (eg clinical, safety, business). |
| **MFT** | Medway NHS Foundation Trust |
| **PSII** | Patient Safety Incident Investigation |
| **LFPSE** | Learn From Patient Safety Events |
| **STEIS** | Strategic Executive Information System |
| **IRG** | Incident Review Group |
| **PSIRG** | Patient Safety Investigation Review Group |
| **SEIPS** | Systems Engineering Initiative for Patient Safety |

## Our patient safety culture

MFT promotes a climate that fosters a just culture by working closely with its staff across all services and listens to their voices. Through various mechanisms the Trust captures rich information about the climate of the organisation and makes BOLD decisions and takes action TOGETHER. This climate of nurturing ‘A Just Culture’ is encapsulated within the Trust’s value of being ‘sharing and open’, whereby we speak up when we see issues that affect the safety and well-being of others, by questioning, challenging and embracing innovation, and by reflecting and sharing what we learn.

MFT recognises the value of having an open and just culture, which is why every year the Trust promotes staff engagement with the annual staff survey to better understand its safety culture. Trust leaders interpret the information gained from the staff survey with great importance and seek to make improvements year on year with the safety culture of the organisation. Similarly, MFT will use other sources of information such as friends and family test responses and staff feedback to obtain an accurate understanding of its culture. More recently MFT has rolled out the Manchester Patient Safety Assessment Framework from the National Patient Safety Agenda (NPSA) to help the organisation assess its progress with developing a safety culture, which it will then use to help evaluate any specific intervention needed for change.

In order to support development of a Just culture, the organisation is undergoing a review and revision of its patient safety related policies and processes to ensure that there is clarity around its patient safety incident responses, and that these are being conducted for the sole purpose of learning and identifying system improvements to reduce risk (not accountability, liability, avoidability or cause of death) and that they do not also undermine a just culture by requiring inappropriate automatic suspensions of staff involved in patient safety incidents or their removal from business as usual activities.

The Trust also subscribes to ‘A Just Culture’ guide whereby wider systemic issues are considered when things go wrong, enabling professionals and those operating the system to learn without fear of retribution. Linked to this is a recognition at MFT that almost all excellence in healthcare is dependent on teams, and that teams work best when all members feel safe and have a voice. This is why the Trust is raising the awareness of the power of civility to saves lives, in recognition that civility between team members creates a sense of safety and is a key ingredient of great teams. One further change that the Trust has initiated in its development of a safer culture is the concept of patient safety-II, which shifts the focus onto what’s going well in a system or process rather than always focusing on what went wrong.

Encapsulating all of the work we have undertaken to promote a climate of a just culture is the language that we use at MFT. We do not apportion blame to staff that have been involved in patient safety incidents and we are BOLD in challenging conversations when blame arises. Equally, as we roll out PSIRF we have moved to using nationally recognised terminology such as patient safety incident investigations and fact finding rather than ‘staff statements’ to denote the focus we a placing on learning and improvement rather than on a level of ‘seriousness’ that is associated with disciplinary procedures. These changes will also enable our staff to feel safer and more confident when starting at MFT as they will be able to recognise NHS-wide incident management methodologies and recognise MFT as a promotor of a just culture.

MFT promotes a number of mechanisms that allow staff, patients, and the public to record patient safety-related issues, concerns and incidents. These include an easily accessible incident management system that can be accessed by all staff at any time to raise a concern. Every single incident raised undergoes a review by the patient safety team and is managed according to guidance within our incident management policy, which includes providing the reporter of the incident with a summary of learning from the incident upon closure. Staff also have the ability to raise any concerns through their line management structures or anonymously via our freedom to speak up (F2SU) guardians. Patients and the public similarly have multiple ways to raise a patient safety related concern including speaking directly to our Patient Advice and Liaison Service (PALS) or by making a complaint to our complaints team. MFT also has two campaigns running throughout the hospital for enabling patients and the public to raise concerns via our ‘don’t take your troubles home’ initiative and our ‘call for concern’ line.

Moving forwards the Trust is focused on undertaking better triangulation of the data that it captures in relation to patient safety concerns. We recognise the importance of linking together valuable sources of information so that we can better understand the culture of the organisation but also so that we can provide the best learning and improvement opportunities to make MFT the safest place for patients and staff.

When things do unfortunately go wrong MFT similarly demonstrates openness and transparency with its regulators at NHS resolution, the Care Quality Commission, the Medicines and Healthcare products Regulatory Agency (MHRA), the ICB, HM Coroners and others. We do this as we are an organisation committed to learning not only when things go wrong, but also when things go right, and we use our regulators to support us in this process and to help us deliver wider improvements at a local, regional and national level.

## Patient Safety Partners

The involvement of patient safety partners (PSPs) is considered an important step in MFTs journey to delivering safer care for patients. We recognise the value of engaging with patient safety partners to improve safety within healthcare and are committed to embedding ‘critical friends’ in all of our quality and patient safety related work streams.

Patient safety partners will be engaged in the design and development of incident response processes including engagement and involvement processes with those involved in a patient safety incident investigation, as set out in our patient safety partners policy. They will also be an important member of providing oversight and scrutiny of MFTs response to patient safety related issues.

We will ensure that our patient safety partners are trained to the necessary level so that their involvement with us delivers the most effective outcomes. We will do this through aligning each PSP to a member of staff from the patient safety team who will support and train the individual in the principles of patient safety, systems engineering initiative for patient safety, human factors, and improvement methodologies. The patient safety partners will also complete the patient safety syllabus levels 1 and 2 training and undertake a formalised programme of training that includes equality, diversity and inclusion, safeguarding, infection prevention and information governance.

Future iterations of our PSIRP will continue to champion the voice of our patients in the areas of local priority for investigation and learning through the engagement with our patient safety partners.

## Addressing health inequalities

MFT is an inclusive organisation that is committed to reducing inequalities of care for its patients and staff. As a result, health equality has been a golden thread running throughout the Trust’s implementation phases of PSIRF and is recognised as a fundamental component of our patient safety incident response processes.

Through undertaking an in-depth analysis of the last three years of patient safety related data, as set out in our PSIRP, we have been able to analyse and triangulate the information at a level never before achieved. By doing this we have been able to identify areas of health equality that have informed our patient safety incident response processes.

Two particular areas that our PSIRP focuses on are ensuring that our methods of communication meet the needs of our patients and their families. Our intelligence analysis told us that we need to ensure that a patient’s specific communication needs are met, every time. Therefore, as part of our response to incidents and learning we will ensure that this is a key focus of consideration when developing any safety actions so that our communication methods e.g. language or understanding barriers, and patient access to information, are in a form that is most appropriate for them.

The second area where our patient safety incident response processes will support health equality and reduce inequality is with our patients that present with a mental health diagnosis or symptoms. Where this is the case we will be taking important steps within our processes and improvement forums to ensure that any inequalities of care or outcome are recognised and that the appropriate support systems are put in place.

Whilst we strive to achieve equity, we also recognise that this can differ between patients, families, and healthcare staff in what they consider is the appropriate response to a patient safety incident. When this is the case the opportunity for learning will be weighed against the needs of those affected by the incident. This is where our patient engagement leads will seek information on the impact of an incident and guide our incident response types whilst being aware of the risk of introducing inequity into the process of safety responses. Our engagement leads will be fundamental in engaging and involving patients, families and staff following a patient safety incident and therefore their role in considering the different needs of patients is paramount to reducing any inequalities for patients.

## Oversight roles and responsibilities

The following details the individual, departmental, committee, group roles and levels of responsibility for incident and SI reporting and investigation

### Chief Executive Officer:

As Accountable Officer has overall responsibility for ensuring compliance with our regulatory and legal responsibilities, ensuring the Trust has a suitable and effective policy, standard operating procedures and infrastructure in place to provide a comprehensive system of internal control and systemic and consistent management of incidents across the Trust. The Chief Executive will delegate specific roles and responsibilities as required, to ensure incident management is coordinated and implemented effectively.

### Chief Nursing Officer:

has delegated board level responsibility for ensuring that processes for investigating and managing incidents are devised, implemented and embedded, reporting to the Chief Executive Officer and Executive Team any significant issues arising from the implementation of this framework including evidence of non-compliance or lack of effectiveness arising from the monitoring process so that remedial action can be taken. They also have delegated board level responsibility for quality, and patient experience and hold the responsibility for risk of non-compliance with regulatory and legal responsibilities such as the CQC fundamental standards.

### Chief Medical Officer:

The Chief Medical Officer will ensure that the Trust takes action upon issues arising from patient safety and clinical risk management. Together with the Chief Nursing Officer, they will champion a strong patient safety culture and lead on Sharing the Learning that arises from investigations.

### Director of Integrated Governance, Quality and Patient Safety:

Has the operational responsibility for ensuring the delivery and effectiveness of the processes for the management of patient safety incidents including timely engagement of patients and families in patient safety incidents, and the direct line management of the patient safety team through which their duties are discharged.

### Patient Safety Specialists:

Have responsibility to ensure the principles of PSIRF are maintained at the organisation and have responsibility to support the implementation and embedding of the patient safety strategy within the organisation.

### All Staff:

Have a responsibility to report patient safety incidents including near misses and no harm incidents via the Trust reporting system to ensure they can be reviewed and corrective and preventative action be put in place to prevent re-occurrence.

### Clinical Staff:

Clinical staff involved in care are responsible for participating in learning events and investigations, to identify system concerns and remedial actions.

### Coroner:

Has a Statutory Duty under Regulation 28 to issue a PFD Report where their investigation gives rise to a concern that circumstances exist which create a risk of future deaths.

### Medical Examiners:

Have a responsibility to escalate to the Trust any deaths where there may be an area of concern which needs further exploration.

## Committees

### Incident Review Group (IRG):

Is co-chaired by the Medical Director for Quality & Safety and Director of Integrated Governance, Quality and Patient Safety and is responsible for reviewing all incidents to determine if they meet the threshold to be declared as a Notifiable Patient Safety Incident, confirming the level of harm and investigation to be completed. The IRG reports to the Patient Safety Group.

### Patient Safety Investigation Review Group (PSIRG):

Is co-chaired by the Medical Director for Quality & Safety and Director of Integrated Governance, Quality and Patient Safety and is responsible for reviewing all PSIIs to determine if appropriate learning has been established from the review. This group has board level authority to approve investigation reports. The PSIRG reports to the Patient Safety Group.

### Quality and Patient Safety Sub-Committee:

Is co-chaired by the Chief Medical Officer and Chief Nursing Officer and has responsibility for monitoring the operational effectiveness of patient safety incidents, including timely compliance with requirements to engage patients and families in patient safety incidents, and duty of candour regulations. The operational management of this function is delegated to the Patient Safety Group.

### Quality Assurance Committee:

Is chaired by a Non-Executive Director of the Trust Board and has responsibility to seek assurance on behalf of the Trust Board as to the effectiveness of the arrangements in place to manage patient safety incidents, including timely compliance with requirements to engage patients and families in patient safety incidents, and duty of candour regulations.

### Health & Care Partnership Quality & Safety Board

Is co-chaired by the chief nursing officers from MFT and Medway Community Health and has a responsibility to assurance for system and partnership quality and patient safety improving outcomes for patients across Medway & Swale.

## Integrated Care Board (ICB) Oversight

**PROCESS SLIDE**

Maintaining positive working relationships with the ICB is essential to the implementation of PSIRF at MFT. With the introduction of PSIRF, new ways of keeping the ICB informed of patient safety matters at the organisation have been established. Whilst the organisation will continue to use the LFPSE and STEIS to report patient safety incidents, the approval and oversight of PSIIs and new learning responses will be as follows:

* Invitation to IRG – this will allow the ICB to gain assurance the Trust is working to it’s PSIRP
* Invitation to PSIRG – this will allow the ICB equal opportunity to scrutinise PSII investigations, to ensure a patient centred approach and application of the SEIPS methodology in investigations.
* Quarterly patient safety focussed reports to MFT provider Quality Meeting for monitoring and assurance.
* It has been agreed that providers can escalate any concerns outside of these meetings to the ICB Patient Safety Team.
* Providers can share existing Patient Safety/Quality reports with ICB.
* Thematic reviews/reports on learning responses to be shared with ICB for wider learning and sharing.
* Improvement visits; announced and unannounced.
* Informal, update meetings on progress with plan & priorities, as these will continuously evolve. Monthly at first, then to be reviewed.
* Single Oversight Framework (SOF) Level and Soft Intelligence will help determine frequency of meetings. This is all subject to change as we move through the PSIRF journey and we reserve the right to adapt and evolve meetings, frequencies and attendance.

# Key Section 1: Reporting

## Reporting an incident

The Trust maintains a central incident reporting system. The Trust’s incident reporting system known as DATIX provides a generic incident form for reporting all incidents; clinical and non-clinical, patient safety and non-patient related incidents.An incident or near miss may be notified or identified by a person who uses our services, visitor, or any staff member. It is important that all staff recognise when an incident or near miss has occurred.

If for any reason access to the electronic reporting system is not available, Please follow: CORP-QUA-BCP-1 Information technology asset business continuity plan available on Q-Pulse.

All incidents and near misses need to be reported no later than two working days after an incident is discovered.

It is the duty of all staff to report an incident or a near miss that has significant potential to cause harm or had caused harm. For registrants of the NMC, GMC or HCPC the Duty of Candour regulation imposes a legal duty (since November 2015) that they report any incident that has caused or may later cause moderate harm or above.

Access to DATIX is via the trust intranet and guidance can be found on the reporting page for what incidents should be reported and what levels of harm should be attributed to certain incidents. Further guidance can also be found by following the link below.

[NHS England » Policy guidance on recording patient safety events and levels of harm](https://www.england.nhs.uk/long-read/policy-guidance-on-recording-patient-safety-events-and-levels-of-harm/)

Should additional support or advice be required on reporting an incident further guidance including contact details for the Patient Safety Team can be found on the trust intranet link below.

[Patient Safety Improvement - The Clock Tower (medway.nhs.uk)](https://intranet.medway.nhs.uk/page/2374?SearchId=551935)

Employees who become aware of actual or potential malpractice are encouraged to come forward without fear of victimisation and speak up <https://qpulse.medway.nhs.uk/QPulseDocumentServiceCorporateLive/Documents.svc/documents/active/attachment?number=CORP-HR-SOP-3>

## Immediate Actions following an incident

**When an incident or near miss is identified, prompt actions are necessary to reduce further risk.** These may include:

* Summoning assistance
* Ensuring the safety of the patient, or other individual(s) involved however, not compromising their own health & safety
* Ensuring that any immediate health needs are met e.g. Providing emergency medical care and treating any injuries
* Informing line managers or Ward/Service Managers
* Removing any faulty equipment from use (marking it clearly “out of order”) and contacting the Estates and Facilities Team
* Notifying senior members of staff on duty, the person affected and/or their family
* Gathering essential information about the chain of events
* Completing a Safeguarding referral, including notifying the police and documenting any action taken by them
* Taking pictures for evidence. These can be uploaded to DATIX
* Requesting that all those who observed what happened prepare a witness statement as soon after the event as possible
* Identifying the level of harm caused or potential risk for harm
* Sharing any immediate learning with colleagues
* Recording the action taken in the patient’s medical records
* Reporting the incident (within 24 hours), including the actions taken following the incident

## Completing Incident Reports

Appropriate details should be entered in the fields provided on the incident form. ***The content must be FACTUAL and NOT include OPINIONS.* *Patient details should not be included within the incident description*.**  (If a future challenge is made to the standard of care or working conditions incident report forms are potentially disclosable to a patient and/or claimant or their representatives.)

Reports can be reported anonymously, but this limits the depth of investigation and analysis and opportunity to learn and improve. In order to receive feedback on the reported incident, staff must use their nhs.net email address.

Once the incident has been reported on DATIX, an automatic notification is provided to key individuals including subject matter experts based on the incident type chosen, e.g. Fire to ensure that prompt and appropriate support is provided.

## Grading Incidents – Impact

Incidents can have an impact on patients and/or staff at various levels, from no harm to death of one or more persons. A best assessment at the time of the incident should be carried out and if, at a later date, more information is received, the incident degree of harm and other details about the incident can be amended.

Following the introduction of the LFPSE in autumn 2023, the Trust has moved to a new harm grading system. This accounts for both Physical harm and psychological harm.

Where practical, it is good practice to discuss the level of harm with the patient affected and to consider the patient’s perspective on the harm definitions stated below.

|  |  |  |
| --- | --- | --- |
| **Previous harm grades** | **New physical harm grades** | **New psychological harm grades** |
| **No Harm** | No physical harm | No psychological harm |
| **Low harm** | Low physical harm | Low psychological harm |
| **Moderate harm** | Moderate physical harm | Moderate psychological harm |
| **Severe harm** | Severe physical harm | Severe psychological harm |
| **Death** | Fatal | n/a |

The full definitions of the harm grading are as follows:

## Physical harm

### **No physical harm**

No physical harm

### **Low physical harm**

Low physical harm is when all of the following apply:

* minimal harm occurred – patient(s) required extra observation or minor treatment
* did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit
* did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication
* did not or is unlikely to affect that patient’s independence
* did not or is unlikely to affect the success of treatment for existing health conditions.

### **Moderate physical harm**

Moderate harm is when **at least one** of the following apply:

* has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
* has limited or is likely to limit the patient’s independence, but for less than 6 months
* has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

### **Severe physical harm**

Severe harm is when **at least one** of the following apply:

* permanent harm/permanent alteration of the physiology
* needed immediate life-saving clinical intervention
* is likely to have reduced the patient’s life expectancy
* needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
* has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
* has limited or is likely to limit the patient’s independence for 6 months or more.

### **Fatal (previously documented as ‘Death’ in NRLS)**

You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

## Psychological harm

Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.

### **No psychological harm**

Being involved in any patient safety incident is not pleasant, but please select ‘no harm’ if you are not aware of any specific psychological harm that meets the description of ‘low psychological harm’ or worse. Pain should be recorded under physical harm rather than psychological harm.

### **Low psychological harm**

Low psychological harm is when **at least one** of the following apply:

* distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
* distress that did not or is unlikely to affect the patient’s normal activities for more than a few days
* distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

### **Moderate psychological harm**

Moderate psychological harm is when **at least one** of the following apply:

* distress that did or is likely to need a course of treatment that extends for less than six months
* distress that did or is likely to affect the patient’s normal activities for more than a few days but is unlikely to affect the patient’s ability to live independently for more than six months
* distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

### **Severe psychological harm**

Severe psychological harm is when **at least one** of the following apply:

* distress that did or is likely to need a course of treatment that continues for more than six months
* distress that did or is likely to affect the patient’s normal activities or ability to live independently for more than six months
* distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

Further guidance and frequently asked questions regarding harm levels can be found here:

[NHS England » Policy guidance on recording patient safety events and levels of harm](https://www.england.nhs.uk/long-read/policy-guidance-on-recording-patient-safety-events-and-levels-of-harm/)

## 

## Engaging and involving patients, families and staff following an incident

The Trust recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. The same is true of other incident types. 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.

The Trust has a separate Engaging Patients & Families in Patient Safety Incidents (Including Being Open & Duty of Candour) Policy & Standard Operating Procedure which describes how the Trust involved those affected by Patient Safety Incidents.

## Daily incident review:

The Patient Safety Team will complete a daily incident review at the beginning of each day (excluding weekends). The Monday morning review will include all incidents reported over the weekend including Friday.

When a new incident is reported the Patient Safety Team will:

* Check that relevant Patients details have been entered in the appropriate section. If this is not completed, this may mean that the investigation is not able to be completed.
* Check the description of the incident to ensure that there is no patient or staff identifiable data. Incident descriptions will also be checked for spelling and grammar and to ensure it has not been completed all in capitals.
* Assignment of the handler of the incident is checked to ensure the most appropriate person is assigned. This may be the Patient Safety Lead/Ward Manager for the particular area, or the specialist lead.
* The location is checked to ensure that this is the area in which the incident occurred. This may differ to the Division, Care Group and Speciality. These must be specific to the patient/area. For example, if it was a Pressure Ulcer that was discovered on a Ward, the location would be the ward but the division would be Corporate, care group Nursing and speciality Tissue Viability. This is to ensure the correct people have access to the incident and can assist in the investigation.
* At this section of the reporting form, any additional teams or locations can be allocated.
* The categorisation of the incident will be checked to ensure this is completed appropriately and correctly.
* The harm level will be reviewed. If an incident has been flagged as potentially meeting the criteria set out in the PSIRP this will be referred to the Incident Response Group (IRG).
* Following the completion of the previous sections, The Patient Safety Team will then complete the Investigation Tab. The review date must be added and the incident must be categorised via multiple choice selection for:
* Local investigation
* Verbal Update to IRG
* Thematic review
* Potential A3 thinking
* AAR
* SWARM
* PSII
* Structured Judgement Review
* At this stage, any specialist investigation types can also be highlighted for example – Medication, Infection Control, Safeguarding, Falls, Tissue Viability, Health and Safety etc.
* Any duplicate records can either be rejected or linked and the duplication closed.
* If known, the incident can be linked to any complaints, inquest and claims data.
* Any incidents highlighted for IRG will be added to the IRG agenda and the IRG SOP will be followed.
* The Patient Safety Team will produce a weekly flash report for all incidents that have occurred that week, which will be shared with relevant colleagues. The weekly flash offers and opportunity for shared learning across all quality domains.

# Key Section 2: Responding to Patient Safety Incidents

## Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, the organisation has outlined within its Patient Safety Incident Response Plan (PSIRP) how it will respond to areas of concern across the next 18 months.

## Resources and training to support patient safety incident response

To ensure adequate resources are dedicated to Patient Safety Improvement the Trust has:

A dedicated Patient Safety Improvement Team (PSIT) who:

* Are trained, Specialist investigators for PSIIs
* Work with a clinical lead as a subject matter expert to complete PSII investigations
* Co-ordinate SWARMs, interviews and debriefs with staff and patients/ families/carers involved in a patient safety incident
* Act as a specialist liaison point for families involved in a PSII to ensure their voice is heard and they are involved with an investigation as much as they would like to be
* Ensure reports are easily understood, free from jargon, and are accessible in different formats including ‘easy read’ where necessary.
* Ensure a systems based approach to investigating outcomes and identifying learning has been undertaken.

Following a review of the Trust capacity for investigations the Trust will endeavour to complete a minimum of 24 PSII per year, determined by the PSIRF priorities in addition to any mandated PSIIs. This is an expected 4 PSIIs per priority. In addition, maternity have an additional 3-5 allocations within the Trust priorities for maternity specific incidents.

It is also possible that emerging or individual incidents may require a PSII. This decision will be made by the IRG. The trust will use an incident decision matrix to support these decisions, however this is not exhaustive and a multidisciplinary approach to decision making will be taken.

There is no outlined requirement for the amount of patient safety learning responses completed by the Trust. Patient safety learning responses will be determined by the incident profile of the organisation to drive patient safety improvement across the organisation.

## Our patient safety incident response plan

Our plan sets out how **Medway NHS Foundation Trust** intends to respond to patient safety incidents over a period of 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

## Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

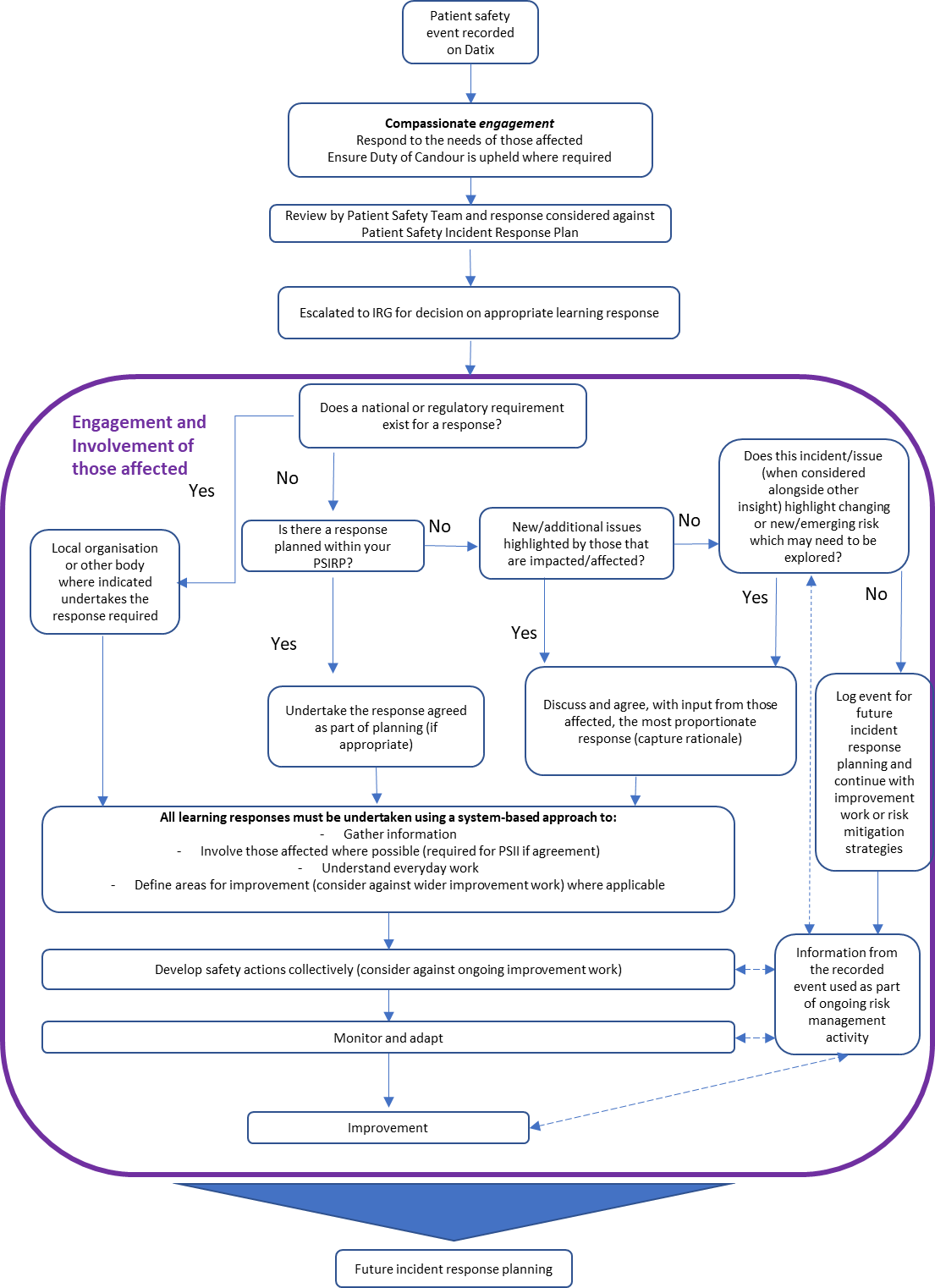
Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

## Responding to patient safety incidents

### Patient safety incident response decision-making

The Trust will use a dynamic response to incident decision making. Every incident reported in the organisation is reviewed to determine the next steps for the investigation. Incidents that meet the PSIRP requirements or are suggestive of a need for a patient safety response will be discussed at the Trust Incident Review Group for multi-disciplinary decision.



### Specialty Nursing Incident Review

Some incidents need to follow a slightly different process. This relates to incidents where there is a corporate nursing team for specialist input. Current investigations in this category include: Tissue Viability, Falls, Infection Prevention and Control, Safeguarding specific incidents.

### Responding to cross-system incidents/issues

In collaboration with other local Trust’s in the region, a process has been agreed for cross system incidents/issues. It identifies a process of collaborative review across organisations to highlight and share learning to improve the experiences of patients and their families and carers. This is for a variety of concerns including transfer of care concerns.

*Forums for feedback loop:*

*Patient safety Community of Practise (COP)*

*Joint review group*

*Medway & Swale Quality & Safety ToCC Group*

*Feedback to patients/families*

*Kent and Medway’s Medicines Optimisation Group*

The following organisations have signed up to participate in collaborative reviews

MCH

DGS/DVH – KCC

Swale/MFT – KCC

West Kent/MGH/TWH -KCC

East Kent/QEQM/WHH/K&C – KCC

G4S

ICB

HCRG

HCRG TOCC queries

SECAmb

MFT

### Timeframes for learning responses

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

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

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

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.)

All patient safety learning responses should be completed within 1 calendar month. In exceptional circumstances, this may be extended to 2 months with IRG agreement and rationale for delays.

### PSII Feedback meeting

It’s important to share the final PSII report with the team in a timely manner. Lack of feedback from incident reporting has been highlighted as inhibiting the willingness of staff to report incidents.

A feedback meeting will be organised by the Patient Safety Improvement team to meet with all persons involved in the incident and the investigation of the incident. This feedback meeting could be via the team’s Huddle or via a separate meeting arranged by the Patient Safety Improvement Team. The feedback meeting will be opened to all involved in the investigation, including any other members of staff within the division who would like to attend in order to facilitate learning. It is good practice for the co-reviewer and medical reviewer (if relevant) to be present at the feedback meeting

This meeting is an opportunity to present, discuss and ask questions about the investigation, findings, recommendations and actions. This meeting should take place within 21 – 45 working days of the investigation process

The corporate governance team will share all completed PSII investigation reports with the relevant divisional leads and key people involved in the incident and investigation as they have been approved. This will ensure that the divisions are sighted on all completed investigation reports and can update regarding implementation of the action plan.

# Key Section 3: Non-Patient Safety Incidents

Any incident reported on the Datix system will require a level of investigation. If the incident relates to a non-patient safety incident, it will be investigated as required by the relevant speciality some of which include:

* Information Governance Incidents
* Health and Safety Incidents
* Fire Safety Incidents
* Risk Incidents
* Emergency Preparedness Incidents
* Security Incident
* HR Incidents
* Safeguarding Incidents

Details regarding each of their investigation processes can be located in the below documents:

* Information Governance Incidents
* Health and Safety Incidents
* Fire Safety Incidents
* Risk Incidents
* Emergency Preparedness Incidents
* Security Incident
* HR Incidents

# Key Section 4: Post Incident Guidance

## Safety action development and monitoring improvement

Relevant, timely, specific actions are vital to make changes to our services to improve safety and the care provided. The Trust will ensure staff are provided with the necessary training and support from the PSIT to develop robust action plans to address contributory factors to an incident to improve patient safety. Action plans will be monitored, reviewed and updated to ensure best practise is embedded and a culture of continuous leaning is encouraged.

## Monitoring of action plans

Action plans produced as a result of safety investigations should be implemented and monitored locally e.g. through Speciality Governance meetings. All actions from Incidents are to be uploaded to the actions module of Datix by the relevant investigating manager.

The Patient Safety Group will seek assurance from regular Datix reports that action plans are being implemented.

Audit can be used to monitor the efficacy of actions.

Trends identified through incidents will be monitored by the Patient Safety Team, Heads of Nursing, Heads of Service, Service Managers, and the appropriate groups.

## Trust wide Quality Improvement plans

The Trust has a series of Quality Improvement Plans (QIP) based on thematic analysis of current and past incidents. A quality improvement plan (QIP) is a document that outlines how an organization or a team will address a specific problem or goal related to quality, efficiency, or effectiveness. A QIP can help you identify the root causes of the issue, set measurable objectives, implement changes, and monitor the results. The current ongoing Trust wide improvement plans are:

|  |  |
| --- | --- |
|  | ***Local* patient safety incident**  **improvement plan/scheme title** |
| 1 | Falls |
| 2 | Tissue Viability |
| 3 | Deteriorating Patient |
| 4 | Mental Health |
| 5 | Safeguarding |
| 6 | Maternity |

Quality Improvement plans (QIPs) are monitored via the Patient Safety Group (PSG) for effectiveness. Each QIP also has a responsible group at which the QIP is monitored. QIPs monitoring will be escalated through the Trust governance structure and feedback provided to the ICB via the PQM meeting and standalone reports where required.

As the Trust progresses from a reactive to a proactive patient safety culture, more QIPs will be developed to address commonly occurring themes across the organisation.

All actions should be recorded on the action module on Datix for development of future QIPS.

## Sharing Learning

One of the key aims of the PSIRF is the learning process which aims to reduce the risk of re-occurrence and avoidable harm, where the incident originally occurred, elsewhere in the organisation and across the NHS. The timely and appropriate dissemination of learning following the review of a PSII is core to achieving this and to ensure that lessons are embedded in practice. Consideration should be given to the sharing of lessons learned at all levels of the organisation.

|  |  |
| --- | --- |
| **Level:** | **Examples of sharing learning** |
| Individual / patient | * Presentations at staff meetings * Team meetings * Trust ‘Spotlights’ and newsletters * Conferences and Sharing the Learning events * Intranet site * Notice boards * Big four * Friday news (maternity) * Emails * Investigation reports * Themes and trends analysis reports * Training sessions * Clinical Supervision/reflective practice * Individual reflections * Datix Incident “feedback” * Sharing the completed investigation report with the affected person who uses services and/or their relative/carer * Meeting with families/carer to give them the opportunity to be involved in the investigation process and providing them with interim findings for their comments |
| Divisionally | * Team meetings /multidisciplinary meetings * Pressure Ulcer/Falls Panels * Other subject specific training courses * Sharing the Learning events * Chief Executive Bulletin * Conferences, seminars and workshops * Learning folders * Use of Patient Stories * Adult Safeguarding Assurance Group * Patient Safety Leads * Feedback meeting organised by the Investigating Manager with the co-reviewer and medical reviewer present to meet with all the persons involved in the incident and the investigation of the incident |
| Service/Directorate | * Divisional Governance meetings * Newsletters * Weekly Quality Flash |
| Trust | * Sharing the Learning Events * Trust wide workshops * Newsletters * Intranet – Sharing the learning page * Through reports and discussion of trends, themes, and patterns at various meetings * Monthly risk and safety induction session delivered * Task and finish groups for various improvement activities to address key issues and themes which emerge from PSIIs * Monitoring and auditing key systems and processes via clinical effectiveness and outcomes plan and policies * Gap analysis against the Trust’s systems and processes undertaken of high profile incidents that occurred in other organisations with the findings discussed at QAC * Completed investigation report and action plans published on the Trust Intranet on the Risk and Safety page to ensure that the findings are shared with all staff (all reports are anonymised) * Reviewing and considering the implication of National reports e.g. Francis report, National Confidential Inquiry * Thematic reviews of common features to a number of incidents. Common features may include similar location, type of incident and the goal of the thematic review is to enable wider systemic learning from the incidents and to ensure that commonalities between individual incidents and investigations are identified and addressed |
| Outside of the Trust | * Providing anonymised information about patient safety incidents recorded on Datix to the Learn from Patient Safety Events (LFPSE) * Undertaking a joint investigation or inviting other NHS Trust to be involved in an investigative process, where an event also involves another agency or as a critical friend to provide an independent view. This will be decided on a case-by-case basis * Sharing of thematic reviews with colleagues via the ICB |

## Training

Training is an important part of ensuring compliance with this policy including high quality incident reporting and investigation. We are committed to equipping staff with the necessary skills required to undertake their roles competently and confidently. In turn, staff must take responsibility for developing these skills and participating in the lifelong learning process

The Patient Safety Team provides the following training:

* Incident Reporting.
* Patient Safety Investigation training for staff leading on investigations/learning responses

Where required, staff will be given the following training:

* Structure Judgement Review training. This will ensure and enable an understanding of how to use the methodology when involved in mortality case note reviews.
* DATIX training for all staff. This will give:
* Context to patient safety and incident reporting principles
* Understanding why and how to report incidents and record actions effectively and accurately taken
* Guidance for all staff on how incidents are reported using DATIX
* Guidance for managers on identifying, managing, and approving incidents on DATIX to meet external reporting requirements, including how to use DATIX to search, report and analyse data for their service area

The above training programme will be available from the Patient Safety Team.

For staff undertaking PSII investigations or leading on learning responses, additional training will be provided. This will include:

* AAR training
* PSII training (2 day course)
* Oversight of learning from patient safety incidents
* Involving those affected by patient safety incidents in the learning process
* Investigative Interviewing
* Human Factors

All staff will undertake Patient Safety Syllabus Level 1 as a mandatory training module. Some staff will undertake Level 2, dependant on their role. Patient Safety Specialists within the organisation will be offered to undertake Level 3 and 4 when available.

## Communication

### Media Interest

Responsibility for developing and managing communications with the media lies with the Trust communications department. No staff member should communicate in any way with the media without first consulting and gaining permission from the Communications Department. Staff must be alert to the media trying to speak and gain confidential information from them. Normally events giving rise to media interest are those graded as serious incidents.

Where there is media interest, the patient and/or their family must be informed and involved in the decision as to whether and what information may be disclosed, before the media are informed or involved.

In forensic and/or criminal cases the police will lead all communications with the media and liaise with relevant agencies involved with the incident.

If an incident involves the potential of a breach of confidentiality or loss of person identifiable information then the incident must be reported and all Information Governance processes and procedures must be followed.

### Process for Staff to Raise Concerns (E.g. ‘Whistleblowing’)

The Trust encourages openness in all aspects of its work and services. On occasions staff may not feel it appropriate to raise a concern, or not feel comfortable about raising a concern, through the normal line management channels e.g. reporting via an Incident Report Form which will be forwarded to managers who may be perceived as part of the problem. The Speak Up – Whistleblowing Policy & Procedure gives staff support and protection to enable them to raise such concerns and should be consulted.

### Supporting Staff

Incidents can be distressing for staff. Staff involved in a complaint or a negligence claim, required to be a witness at an inquest hearing, or required to attend an Employment Tribunal (ET) as a Trust witness, may also suffer stress (especially if significant harm has resulted). If inadequately supported, staff may be unable to provide care to the best of their ability for patients and/or may go off sick. It is not only just, fair and compassionate, but it is in everyone’s interest to support staff appropriately.

Immediate (or as soon as practicable) ongoing support should be proactively offered to staff by line managers, senior staff and other Trust staff as applicable.

Members of the Patient Safety team, Legal Services team and Health and Safety & Integrated Governance team can provide staff with support and advice. Surveys of staff involved in incidents, inquests, complaints, or claims will be carried out to continuously improve the support service offered with the aim of offering the best support possible.

### Briefing the Board

The Chief Nursing Officer and/or Medical Director will be responsible for briefing the Trust Board in relation to patient safety incidents (including Never Events). Where media interest is anticipated, the communications department will brief the Board outside of board meetings.

### Incidents subject to a complaint or claim

In some cases, where a complaint or claim relates to an investigation or review, or there is the potential for an incident or death to become a complaint or claim. It is appropriate for the investigation or review to include the questions to be addressed from the complaints (if relevant) or claims in the investigation or review. The Patient Safety Team will discuss and agree how the investigation or review will inform the complaints (where relevant to the investigation) or claims management process.

The Complaints team will write to the complainant following discussion with them and inform them that an investigation or review is currently being carried out and the questions relevant to the investigation will be incorporated within the investigation or review; if they remain unhappy with the outcome, they are invited to come back to the Complaints Team. If complaint or a claim is received relating to an unreported incident, the complaints or claims team will ensure the manager for the area:

* Completes the Incident Report Form and that the incident is subsequently managed according to the Incident Management policy
* Identify why the incident was not initially reported and take actions to ensure incidents are reported in future
* Following settlement of a claim, the legal services team will liaise with the Head of CRS Manager to undertake a retrospective review of the incident to identify any further learning

### Staff performance identified through an incident

Disciplinary and incident investigations are separate processes, and each process could contaminate the other. On occasions, if during the investigation, elements of misconduct/gross misconduct or poor staff performance are identified, this will be referred to HR for advice and guidance.

If a disciplinary investigation and report is required, it will be a separate process and conducted independently of the PSII or learning response, in accordance with the disciplinary policy. The two investigation processes can run in parallel - if the investigations do not in any way interfere with each other

### Legal services

Coroner Process: When a death is sudden, unexpected, violent or unnatural, the Coroner will decide whether to hold a post-mortem and, if necessary, an inquest. The Coroner’s court is a court of law, and accordingly the Coroner may summon witnesses to attend and give evidence. It is a legal requirement to attend, and failure to do so may result in a charge of contempt of court

The Legal Services Team will work with the corporate and divisional teams to obtain witness statement for the relevant incidents, working with the Health and Safety Manager for staff specific injuries.

If the Coroner identifies an unexpected death for the first time, the Trust would be notified. The incident must be reported on Datix to generate an incident number and commence investigation as per this policy. The Coroner may raise a Prevention of Future Death Report (Regulation 28) following an inquest and it may be at this stage that a PSII is raised. If the Coroner issues a ‘Prevention of Future Death Report’, and the death was not previously investigated as a PSII, then this must be escalated, and the investigation process followed (see Inquest Policy).

Where an inquest outline findings/recommendation not already identified by an incident investigation. The Legal Services Manager will work closely with the Deputy Director of Integrated Governance, Quality and Patient Safety to ensure the new actions identified are shared with the relevant divisional director and divisional representatives and are included in the action plan monitoring tracker by the head of patient safety.

The legal service team will inform the Deputy Director of Integrated Governance, Quality and Patient Safety of the inquest outcome.

This will enable the head of patient safety to update DATIX.

### Reporting to external agencies/organisations

Where required through local or national protocol, we are required to inform external agencies and organisations in the event of specific types of incidents:

* Learn from Patient Safety Events LFPSE (formerly National Reporting and Learning System). This is undertaken by automatic upload from DATIX
* Health and Safety Executive (HSE). Reporting certain incidents and certain work-related diseases of staff or dangerous occurrences to the HSE. RIDDOR requires the incidents of a specific nature to the HSE. This is done via the Health and Safety Manager.
* Medicines and Healthcare Products Regulatory Agency (MHRA): any incidents relating to medical equipment should be notified formally to MHRA using the relevant form supplied by that office. Incidents relating to adverse drug reactions are reportable on the yellow forms.
* NHS Estates: the trust is required to report incidents relating to Fire, buildings, plant, and non-medical equipment to NHS Estates. The Health and Safety Manager will inform the Estates Team who will report such incidents via the Estate return Information Collection system.
* NHS Resolution (NHSR): incidents where there are likely to be civil claims require, where practicable, to be notified to the NHRS as early as possible. The Legal Services Team and Health and Safety Manager will be notified of such incidents via the daily Datix review carried out a corporate patient safety team to enable as much information to be gathered prior to reporting. The Legal Services Team will contact NHSR as appropriate.
* Environmental Health Office and Food Standards Agency: incidents relating to food will, in addition to being notified internally using Datix. This will be done via the Facilities Team only
* Reporting PSIIs to commissioners via the STEIS systems. This is done via the corporate patient safety team

### Supporting patients, families and carers affected by PSIs.

The Trust is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned. The Engaging Patients and Families in Patient Safety Incidents Including Being Open and Duty of Candour sets out the responsibilities and guidance surrounding being open and Duty of Candour.

For the Patient Safety Incident Investigations identified in this PSIRP family liaison/engagement will be undertaken directly by the PSIT Lead for the investigation. As part of our continuous training rollout, additional engagement leads will be identified and trained to support patients/families/carers through a Learning response.

For all other types of Patient Safety Review family liaison it is the responsibility of the nominated Clinical Lead.

## Complaints and appeals

The Trust has a Patient Complaint and Feedback Management Policy where concerns cannot be resolved as part of the investigative process.

The following routes are in place for the people who use our services, their families and carers to make a complaint, raise concerns or provide feedback:

### Raising a concern – Don’t take your troubles home:

The people who use our services, their family or carer should be able to raise a concern or feedback with any member of staff during their care or treatment with the opportunity for this to be resolved locally without the need for intervention by the PALS or Complaints Team.

### Patient Advice & Liaison Service (PALS):

The Patient Advice & Liaison Service (PALS) managed by the PALS and Complaints Manager offers confidential advice, support and information on health-related matters. They provide a point of contact/escalation for the people who use our services, their families and carers.

### Informal Complaints:

The route for the people who use our services, their families or carers to informally raise concerns, issues or feedback for resolution at a service level, with the ability to escalate to a formal complaint should the issue remain unresolved. Submission can be verbal or in writing to the service or the PALS & Complaints Team. The service/care group will manage informal complaints.

Telephone 01634 825004

Email: [medwayft.pals@nhs.net](mailto:medwayft.pals@nhs.net)

### Formal Complaints:

The formal route for handling complaints, managed by the PALS & Complaints Team, whereby a complaint can be made by:

Telephone: 01634 825216

Email: [medwayft.complaints@nhs.net](mailto:medwayft.complaints@nhs.net)

Post: The Central Complaints

Medway Maritime Hospital

Gillingham

Kent

ME7 5NY

Complaints and concerns received will be assessed and where a formal complaint is received the PALS & Complaints Team will acknowledge the complaint within 3 working days. The Trust aims to respond to formal complaints within 25 working days, although complex complaints may take up to and over 60 days.

### Friends & Family Test:

The Friends and Family Test (FFT) is a service level nationally mandated survey relating to the most recent episode of care and is usually sent by text message, card or electronic submission. The Patient Experience Team are responsible for the management of FFT across the Trust.

### NHS Choices / Care Opinion:

Care Opinion is a system where the people who use our services, their families or carers can share their experiences of the care and treatment received at MFT. The Patient Experience Team will respond to feedback and refer concerns to the appropriate route for investigation.

### Local Surveys:

The Patient Experience Team is responsible for conducting local surveys of the people who use our services, their families or carers to enable them to share their experiences of the care and treatment received. The Patient Experience Team will respond to feedback and refer concerns to the appropriate route for investigation.

### National Surveys:

National Surveys are mandated by the Care Quality Commission and provide an opportunity for the people who use our services and/or their families and carers to provide feedback of the care and treatment received during the set survey period, with National benchmarking results published. The Patient Experience Team are responsible for ensuring the Trust participates within all mandated surveys, producing improvement action plans where required.

# Appendices

## Appendix 1: IRG Incident Decision Guidance and Matrix

Please note this is for guidance only – this does not have to be followed if a different level of investigation is felt to be more beneficial. There will be a multidisciplinary approach to decision making.

Once the level of investigation has been agreed, a quick discussion is needed to establish who should attend the required learning response meeting and who the Clinical Lead should be.

**Checklist for providing verbal update at IRG and points to discuss following presentation of incident:**

* Summary of what happened?
* What should have happened?
* What immediate actions have taken place?
* How have the staff been supported?
* How have the patients been supported?
* Which learning response do we think is best?
* Who is the clinical lead? Which staff members need to be involved?
* Level of harm confirmed for Duty of Candour (DOC)/Being Open purposes? Who will complete verbal DOC?
* What key staff members need to attend any meetings to be arranged once level of investigation agreed?

**Types of Investigation**

**SWARM huddle** - S*hould be held as soon as possible, ideally within 48 hours of the incident to focus of what the team need to do and immediate safety. These will be conducted by wards/specialities/care groups* ***prior to or outside of IRG.*** *The**Patient Safety & Improvement team will provide training and support.*

**A3 Thinking Group -** *The A3 format tells the whole story on one page (an A3 sheet), utilising systems based- Root Cause Analysis to understand the issues and Plan, Do, Study, Act (PDSA) to drive improvement. Led by Patient First/Transformation team.*

**Thematic Reviews** - *Identify patterns in data to help answer questions, show links or identify issues.*

**AAR (After Action Review)** - *A method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid recurrence and promote success for the future.*

**PSII (Patient Safety Incident Investigation)** - *Undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.*

**Learning Response Matrix**

**Note: A Safeguarding Review is a learning response option for relevant cases where Nationally-defined incident criteria for Safeguarding is not met.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PSIRF Priorities**  **Themes and Improvement Work** | 1. Not covered in PSIRP | 2. One or some elements meet local PSIRF priorities | 3. Local PSIRF priority | 4. Nationally-defined incidents requiring local PSII / Nationally defined priorities to be considered for PSII or review by another team |
| 1. No learning identified/Individual learning only |  |  |  |  |
| 2. Known issue/theme – addressed by ongoing improvement work |  |  |  |  |
| 3. Known issue/theme – not under ongoing improvement work or improvement work does not address the learning |  |  |  |  |
| 4. New emerging issue/theme – for review to support improvement work |  |  |  |  |
| 5. New issue/theme – requires immediate learning response and improvement work |  |  |  |  |
| **LOCAL INVESTIGATION** |
| **A3 THINKING GROUP/THEMATIC REVIEW IF CLUSTER OF CASES** |
| **AAR** |
| **PSII** |

Please note this is for guidance only – this does not have to be followed if a different level of investigation is felt to be more beneficial. There will be a multidisciplinary approach to decision making. Focus is on the significance of learning. If an incident does not meet any of the PSIRF criteria but there appears to be significant learning, we can make the decision to complete a learning response.

**Local Patient Safety Priorities**

|  |  |
| --- | --- |
| **Incident Type** | **Incident Description** |
| **1. Escalation and Care of Deteriorating Patients/Failure to Rescue** | Incidents where failures in the early, detection, escalation and care of a patient whose condition was deteriorating, led to an adverse outcome for that patient. |
| **2. Patient Handover** | Incidents where the handover of a patient either internally or externally led to an adverse outcome for a patient or unnecessary readmission. |
| **3. Diagnostic Testing** | Incidents or groups of incidents where failure to follow up on diagnostic tests has led to an adverse outcome for that patient or where a misdiagnosis has been made. |
| **4. Medication Incidents** | Incidents or groups of incidents where an error or delay in administration or prescribing of medication led to an adverse outcome for the patient. |
| **5. Delays in Treatment** | Incidents or groups of incidents where a delay in treatment of a patient due to multifactorial issues has led to an adverse outcome for a patient. |

**Nationally-defined incidents requiring local PSII**

* **Deaths thought more likely than not due to problems in care** (incidents meeting the learning from deaths criteria for PSII)[[1]](#footnote-2)
* Incidents that meet the criteria set in the **Never Events** 2018 or its replacement:
* Wrong site surgery
* Wrong implant/prosthesis
* Retained foreign object post procedure
* Mis-selection of a strong potassium solution
* Administration of medication by the wrong route
* Overdose of insulin due to abbreviations or incorrect device
* Overdose of methotrexate for non-cancer treatment
* Mis-selection of high strength midazolam during conscious sedation
* Failure to install functional collapsible shower or curtain rails
* Falls from poorly restricted windows
* Chest or neck entrapment in bed rails
* Transfusion or transplantation of ABO-incompatible blood components or organs
* Misplaced naso- or oro-gastric tubes
* Scalding of patients
* Unintentional connection of a patient requiring oxygen to an air flowmeter
* **Deaths of patients detained under the Mental Health Act** (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)
* **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 care provided. In these circumstances a PSII or other locally led learning response may be required in addition to the LeDeR review.

**Nationally defined priorities to be considered for PSII or review by another team**

* **Maternity and Neonatal incidents** – incidents which meet the “each baby counts” and maternal deaths criteria must be referred to Maternity and Newborn Safety Investigations MNSI (previously HSSIB) for an independent PSII.
* **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). A locally-led PSII may be required.
* **Child deaths** - Refer for Child Death Overview Panel (CDOP) review. A locally-led PSII may be required.
* **Safeguarding Incidents** - Refer to local authority safeguarding lead.
* **Incidents in NHS screening programmes** – these must be reported to Public Health England in the first instance for advice on reporting and investigation.
* **Deaths in Custody** (police custody, prison etc.) must be referred to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations.
* **Domestic Homicide** - A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case.

**If an incident does not meet any of the above criteria but there appears to be significant learning, we can make the decision to complete a learning response.**

**Levels of Harm (for Duty of Candour purposes only)**

No Physical Harm/No Psychological Harm

Low Physical Harm – Minimal harm occurred which did not require further healthcare or further treatment. Harm did not affect the patient’s independence or affect existing health conditions.

Low Psychological Harm – Does not require extra treatment or affect patient’s normal activities.

Moderate Physical Harm – The patient is likely to need further healthcare which may last anything up to 2 weeks additional inpatient care or 6 months of further treatment.

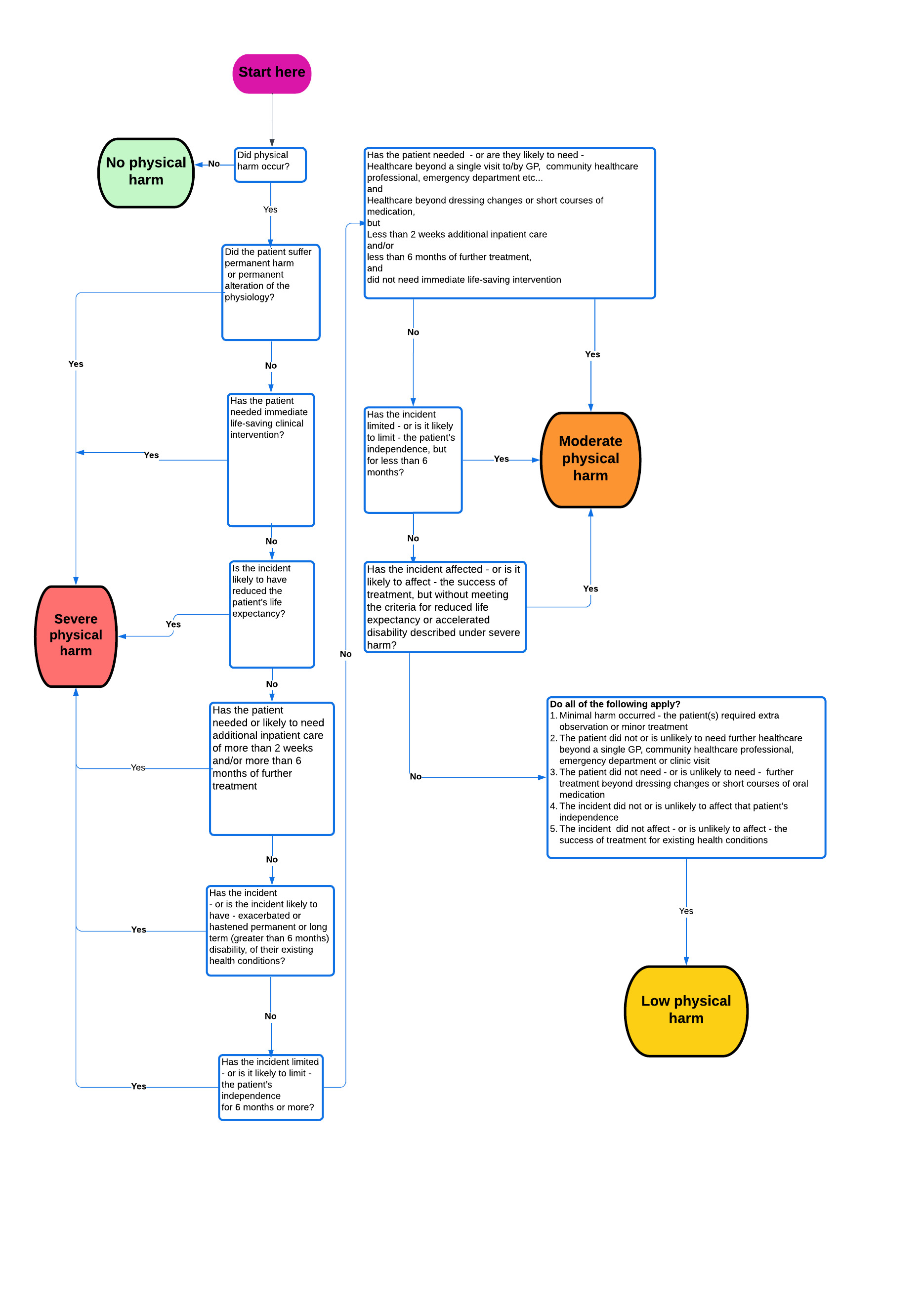
Moderate Psychological Harm – Distress that may need a course of treatment for less than 6 months. Distress that may affect normal activities for more than a few days.

Severe Physical Harm – Permanent harm caused. Harm that may need immediate life-saving treatment and may potentially reduce the patient’s life expectancy. May require additional inpatient treatment of more than 2 weeks or further treatment for more than 6 months.

Severe Psychological Harm – Distress that may need a course of treatment lasting longer than 6 months. Distress that may affect the patient’s normal daily activities for more than 6 months.

Fatal

**Physical Harm Flow Chart**

**Note: This should only be used if harm was caused by or is attributable to MFT. This should not be used to determine the outcome for the patient.**

## Appendix 2: Specialty Nursing risk matrix

Use this matrix to determine the risk score of reported incidents for IPC, Safeguarding, Tissue viability and Falls. The colour banding identifies the rating and guides the level of onward reporting and investigation. The score should be re-calculated following learning identified to reduce the risk.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Potential impact of Learning Outcome** | **Impact to Patient** | | | | |
| 1  No impact to patient quality of life/ no increase in LOS | 2  Some short term impact to patient/ No increase to LOS | 3  Short to Mid-term impact/ Increase in LOS | 4  Long term impact to patient quality of life including after discharge/ Increased LOS | 5  Death of patient/ Loss of quality of life |
| 1. No learning identified/Individual learning only |  |  |  |  |  |
| 2. Known theme – Addressed by ongoing improvement work |  |  |  |  |  |
| 3. Known theme – Not under ongoing improvement work. Potential to inform ongoing improvement work |  |  |  |  |  |
| 4. New emerging theme – for review to support improvement work |  |  |  |  |  |
| 5. New theme – requires immediate learning response and improvement work |  |  |  |  |  |
|  | Local Investigation | | | | |
|  | SWARM (Mini toolkit) | | | | |
|  | AAR (Full toolkit) | | | | |
|  | PSII | | | | |

## Appendix 3 – AAR template

AFTER ACTION REVIEW REPORT

Points to consider:

Date of Incident:

The Event:

After Action Review Date:

Lead of AAR:

Attendees:

WEB number:

Level of Harm:

DOC applicable: YES/NO (please delete as appropriate)

The Event (What happened):

How is the Patient now?

Expected Outcome:

The Outcome/Analysis (What was the difference in the expected outcome and the actual outcome):

Contributory Factors:

Immediate Actions taken:

Areas for Improvement:

## Appendix 4 – Thematic review template

## with thanks to Dr Samantha Machen University Hospitals Sussex.

**Themed Review (TV) template**

**What is this for?**

A themed review may be useful in understanding common links, themes, or issues within a cluster of investigations or incidents. It will seek to understand key barriers or facilitators to safety using reference cases (e.g. individual DATIX incidents or previous investigations).

**What may benefit a themed review?**

Grouped incidents, for example from the same portfolio like pressure ulcers, falls or deteriorating patient, may benefit from a themed review because they take the same safety concern and identify different reference cases and contexts. This helps the organisation make sense of the safety concern at different points of the system and with different aspects of variability e.g. staffing issues, high volume of acute patients. This is important, because safety incidents may occur when systems are ‘pushed’ or ‘pressurised’ and therefore our view of safety needs to be flexible to the variability around the context.

**What should the output of a themed review be?**

Themed reviews may identify fallibilities of the components of a safety system. For example, it may be that across all the reference cases a risk assessment was completed but the preventative measures were not actioned. Outputs of themed reviews can highlight these problems and identify safety recommendations. Themed reviews may provoke more questions than answers, and therefore may be best placed to link in to a quality improvement project for ongoing monitoring and PDSA-style improvement cycles. A themed review should be viewed as a diagnostic tool to help diagnose problems in the system, and therefore doing a themed review should **always** result in some improvement efforts after this diagnosis.

**What are the stages of a thematic review?**

Stage 1: Description of the reference cases

Stage 2: Description of the safety system

Stage 3: Relevant context to each reference case and key problems

Stage 4: Common themes across the reference cases – narrative analysis

Stage 5: Safety recommendations and future work

**Stage 1: Description of the reference cases**

*(In this stage, use the table below to list the reference cases using the headings. Remember, reference cases are the different incidents you are including in the themed review)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Datix number** | **Harm** | **Description** | **Investigation level** | **Actions taken** |
| *Date of reference case* | *Datix number for reference case* | *Harm level for reference case* | *Description of incident and findings of investigation (if applicable)* | *Level of investigation done (e.g. local investigation/RCA)* | *Actions taken as a result of individual incidents e.g. any recommendations/action plans from RCAs* |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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**Stage 2: Description of safety system**

*(In this stage, describe the system of safety for the problem. That is, what safeguarding is in place to ensure patients’ safety? This could be a list or a diagrammatic flow chart. Where there may be different systems in place (e.g. different processes for different locations or multiple safety risks), break them down in the box below.*

E.g. A system of safety for falls below:

Repeat risk assessment

Communication of risk at shift handover

Preventative measures put in place (1:1 care/medication optimisation)

Patient risk assessed for falls

E.g. System of safety for deteriorating patient:

* Patient identified as being at risk of deterioration (clinical notes/observations)
* Clinical task of collecting observation data and calculating (NEWS2 score)
* Preventative/clinical measures put in place (e.g. increased observations/sepsis bundle)
* Senior review of deteriorating patient

**System of safety for specific safety risk:**

**Stage 3: Relevant context to each reference case and key problems**

**E.g. Safety barrier 1: Risk assessment for VTE**

What is supposed to happen? *Risk assessment done within X hours*

What did happen? *Risk assessment delayed by Y hours*

Why did this happen? *Junior doctor not aware of need to do risk assessment before prescribing enoxaparin and is used to prescribing it for all patients. Limited time to do assessment before prescription given volume of patients in the ED department and pressure to reconcile medications*

What can we learn from this? Importance of risk assessments prior to prescription was not clear to this prescriber. Need to identify why this is. Tendency to prescribe enoxaparin as a departmental norm.

*Safety barrier 1:*

|  |  |
| --- | --- |
| **What was supposed to happen?** | **What did happen?** |
| **Why was there a difference?** | **What can we learn from this?** |

*Safety barrier 2:*

|  |  |
| --- | --- |
| **What was supposed to happen** | **What did happen** |
| **Why was there a difference?** | **What can we learn from this?** |

*Safety barrier 3:*

|  |  |
| --- | --- |
| **What was supposed to happen?** | **What did happen?** |
| **Why was there a difference?** | **What can we learn from this?** |

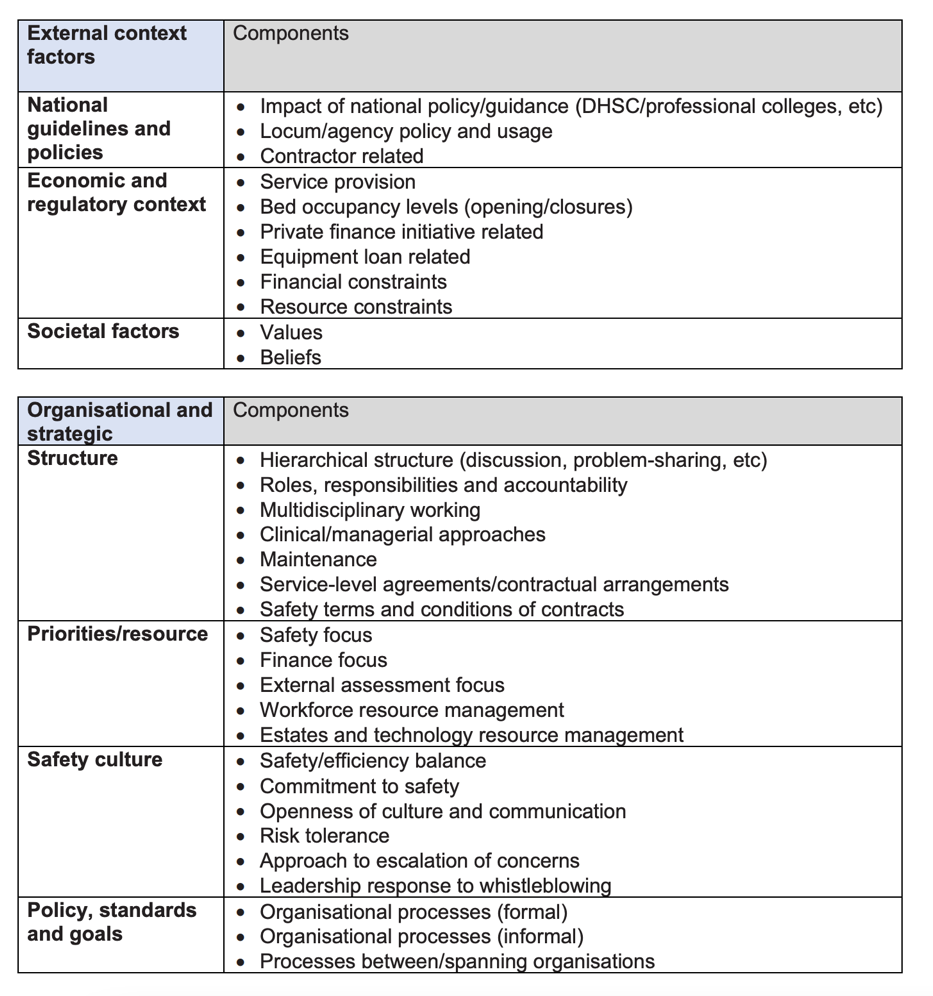
*Safety barrier 4:*

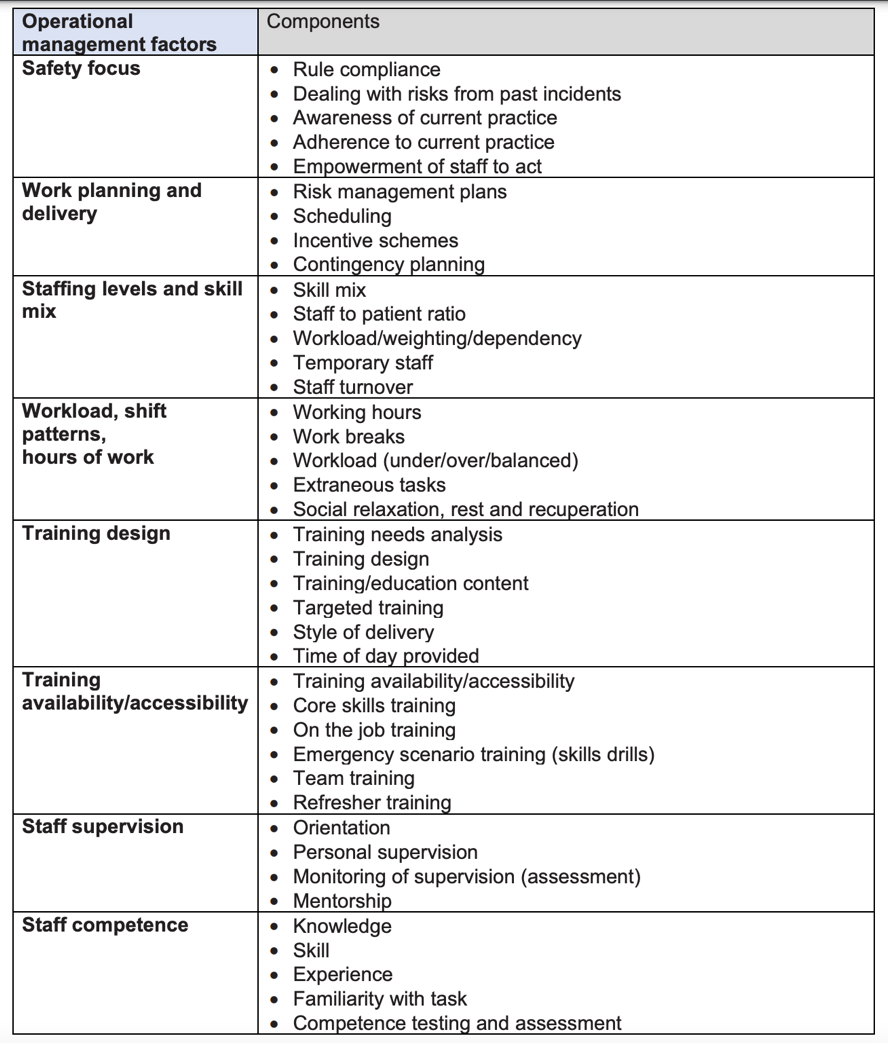
|  |  |
| --- | --- |
| **What was supposed to happen?** | **What did happen?** |
| **Why was there a difference?** | **What can we learn from this?** |

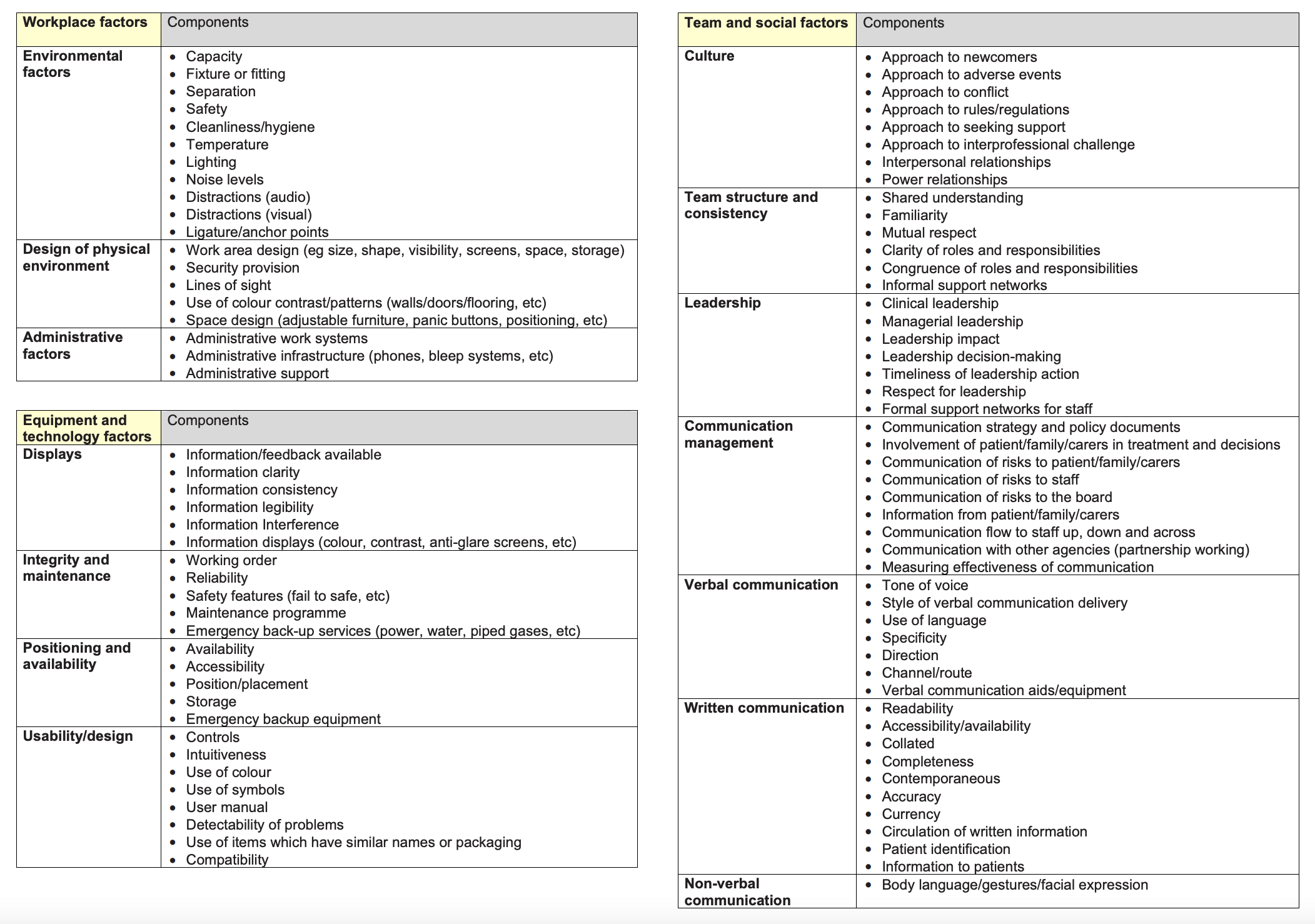
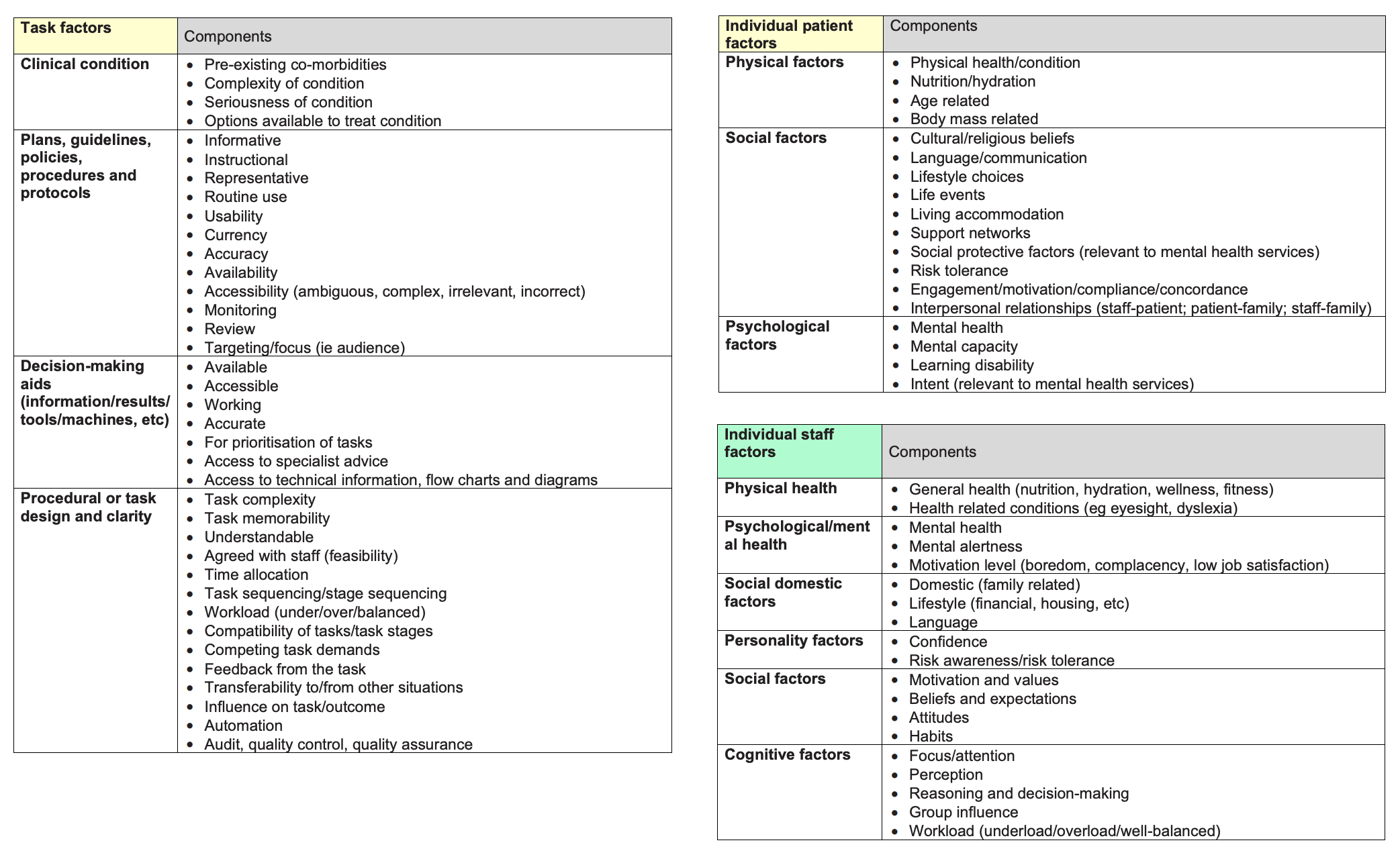
|  |  |
| --- | --- |
| **What was supposed to happen?**  *Safety barrier 5:* | **What did happen?** |
| **Why was there a difference?** | **What can we learn from this?** |

**Stage 3: Relevant context to each reference case and key problems**

This stage refers to contributory factors (as classified by the contributory and mitigating factors classification here: <https://www.england.nhs.uk/wp-content/uploads/2020/08/PSII_Contributory_and_Mitigation_Factors_Classification.pdf>)

For each incident, mark down the external context factors, organisational and strategic, workplace, equipment, and task factors that affected the safety incident. All components that fall under each group can be seen below.



*Mark the factors that affected each reference case based on the description above:*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Causal Factors** | **Domain** | **Components** | **Contributory, Causal and Mitigating Factors Analysis – for identified PROBLEMS/WEAKNESSES** and **STRENGTHS** | | | | | | | | | | |
| **Incident numbers** | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **CONTRIBUTORY and MITIGATING FACTORS** Described as they relate to the **PROBLEMS/WEAKNESSES and STRENGTHS** identified (NB: There may be none, one or more CF/MF in each category) | **External Contextual Factors** | *National guidelines and policies* |  |  |  |  |  |  |  |  |  |  |
| *Economic and regulatory context* |  |  |  |  |  |  |  |  |  |  |
| *Societal factors* |  |  |  |  |  |  |  |  |  |  |
| ***Total*** | |  |  |  |  |  |  |  |  |  |  |
| **Organisational Strategic Factors** | *Structure* |  |  |  |  |  |  |  |  |  |  |
| *Priorities/resource* |  |  |  |  |  |  |  |  |  |  |
| *Safety culture* |  |  |  |  |  |  |  |  |  |  |
| *Policies, standards, and goals* |  |  |  |  |  |  |  |  |  |  |
| ***Total*** | |  |  |  |  |  |  |  |  |  |  |
| **Operational Management Factors** | *Safety focus* |  |  |  |  |  |  |  |  |  |  |
| *Workplanning and delivering* |  |  |  |  |  |  |  |  |  |  |
| *Staffing levels and skill mix* |  |  |  |  |  |  |  |  |  |  |
| *Workload, shift pattern, hours of work* |  |  |  |  |  |  |  |  |  |  |
| *Training* |  |  |  |  |  |  |  |  |  |  |
| *Staff supervision* |  |  |  |  |  |  |  |  |  |  |
| *Staff competence* |  |  |  |  |  |  |  |  |  |  |
| ***Total*** | |  |  |  |  |  |  |  |  |  |  |
| **Workplace Factors** | *Environmement factors* |  |  |  |  |  |  |  |  |  |  |
| *Design of physical environment* |  |  |  |  |  |  |  |  |  |  |
| *Administrative factors* |  |  |  |  |  |  |  |  |  |  |
| ***Total*** | |  |  |  |  |  |  |  |  |  |  |
| **Equipment & Technology Factors** | *Display* |  |  |  |  |  |  |  |  |  |  |
| *Integrity and maintenance* |  |  |  |  |  |  |  |  |  |  |
| *Positioning and availability* |  |  |  |  |  |  |  |  |  |  |
| *Usability/design* |  |  |  |  |  |  |  |  |  |  |
| ***Total*** | |  |  |  |  |  |  |  |  |  |  |
| **Team & Social Factors** | *Culture* |  |  |  |  |  |  |  |  |  |  |
| *Team structure and consistency* |  |  |  |  |  |  |  |  |  |  |
| *Leadership* |  |  |  |  |  |  |  |  |  |  |
| *Communication management* |  |  |  |  |  |  |  |  |  |  |
| *Verbal communication* |  |  |  |  |  |  |  |  |  |  |
| *Written communication* |  |  |  |  |  |  |  |  |  |  |
| *Non-verbal communication* |  |  |  |  |  |  |  |  |  |  |
| ***Total*** | |  |  |  |  |  |  |  |  |  |  |
| **Task Factors** | *Clinical condition* |  |  |  |  |  |  |  |  |  |  |
| *Plans/policies/procedures in place for task* |  |  |  |  |  |  |  |  |  |  |
| *Decision making aids* |  |  |  |  |  |  |  |  |  |  |
| *Procedual or task design and clarity* |  |  |  |  |  |  |  |  |  |  |
| ***Total*** | |  |  |  |  |  |  |  |  |  |  |
| **Individual Patient Factors** | *Physical factors* |  |  |  |  |  |  |  |  |  |  |
| *Social factors* |  |  |  |  |  |  |  |  |  |  |
| *Psychological factors* |  |  |  |  |  |  |  |  |  |  |
| ***Total*** | |  |  |  |  |  |  |  |  |  |  |
| **Individual Staff Factors** | *Physical health* |  |  |  |  |  |  |  |  |  |  |
| *Psychological factors* |  |  |  |  |  |  |  |  |  |  |
| *Social/domestic factors* |  |  |  |  |  |  |  |  |  |  |
| *Personality factors* |  |  |  |  |  |  |  |  |  |  |
| *Social factors* |  |  |  |  |  |  |  |  |  |  |
| *Cognitive factors* |  |  |  |  |  |  |  |  |  |  |
| **Incident numbers** | | | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

**Stage 4: Narrative analysis**

*Use the space below to compile narrative data surrounding the above sections. For example, if 2 or more incidents have a X by the group, then clarify the similarities/differences in the boxes below:*

|  |  |
| --- | --- |
| **External Contextual Factors** | *E.g., How did national guidelines affect the reference cases?* |
|  |
|  |
| **Organisational Strategic Factors** | *E.g., How did local guidelines/organisational resource affect the reference cases?* |  |
|  |  |
|  |
| **Operational Management Factors** | *E.g., How did local organisational level factorsl (e.g. staffing, skill mix, training, and staff supervision) affect the reference cases?* |  |
|  |  |
|  |
| **Workplace Factors** | *E.g., How did environment factors/design of workplace affect the reference cases?* |  |
|  |  |
|  |
| **Equipment & Technology Factors** | *E.g., How did equipment/technology affect the reference cases?* |  |
|  |  |
|  |
| **Team & Social Factors** | *E.g., How did local team dynamics/team culture/leadership/communication affect the reference cases?* |  |
|  |  |
|  |
| **Task Factors** | *E.g., How did task clarity/decision-making prompts affect the reference cases?* |  |
|  |  |
|  |
| **Individual Patient Factors** | *E.g. How did individual patient factors (e.g. acuity/clinical/psychological) affect the reference cases?* |  |
|  |  |
|  |
| **Individual Staff Factors** | *E.g. How did individual staff factors (e.g. social/psychological) affect the reference cases?* |  |
|  |  |
|  |

**Stage 5: Safety recommendations**

In this section, linking to the sections above, list the safety recommendations based on this thematic review using the Standard Quality Improvement Action Plan (Appendix 8)

## Appendix 5 - Specialty Toolkits

### Appendix 5.1 Falls AAR

**AFTER ACTION REVIEW (Full toolkit)**

**Inpatient Fall**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name** | | |  | | | | | | **Date of Birth** | | |  | |
| **NHS Number** | | |  | | | | | | **Hospital number** | | |  | |
| **Date of incident** | | |  | | | | | | **Datix number** | | |  | |
| **Ward** | | |  | | | | | | **Level of Harm at time of SWARM** | | |  | |
| **Confirmed Harm** | | |  | | | | | | **DOC Status** | | |  | |
| **Safeguarding referral required** | | | **Yes**  **No** | | | | | | **Dols** | | |  | |
| **SWARM Date** | | |  | | | | | | **Lead of SWARM** | | |  | |
| **Attendees at SWARM** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Description of Incident: (Time line if required)** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **How is the patient now and Expected outcome** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Investigation**  (**Confirm Yes/No or N/A depending on evidence in notes. Then tick if it if it is a causative factor to the fall)** | | | | | | | | | | | | | |
| Possible Contributing Factors | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| **C-Call Bell Not applicable to this incident** | | | | | | | | | | | | | |
| Within reach of patient | |  |  |  | |  | |  |  | | | | |
| Functioning/working | |  |  |  | |  | |  |  | | | | |
| Appropriate for patient use | |  |  |  | |  | |  |  | | | | |
| Placement re: dominant side | |  |  |  | |  | |  |  | | | | |
| **R** – Review medication  Polypharmacy | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| High risk medications | |  |  |  | |  | |  | List current medication | | | | |
| Medication reviewed pre and post fall | |  |  |  | |  | |  | Pre *Yes*   No  Post *Yes*   No | | | | |
| Med. change in the last 24 hours (dose, time, etc.) | |  |  |  | |  | |  |  | | | | |
| Anticoagulant | |  |  |  | |  | |  |  | | | | |
| Polypharmacy | |  |  |  | |  | |  |  | | | | |
| Medication overdose | |  |  |  | |  | |  |  | | | | |
| **A** – Appropriate equipment | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| **Bed in** | | | | | | | | | | | | | |
| **Bed involved** | |  |  |  | |  | |  |  | | | | |
| Height/position | |  |  |  | |  | |  |  | | | | |
| Brakes on/off/intact | |  |  |  | |  | |  |  | | | | |
| Ultra-low bed | |  |  |  | |  | |  |  | | | | |
| Bed rails involved | |  |  |  | |  | |  |  | | | | |
| Bed rail in line with Ax | |  |  |  | |  | |  |  | | | | |
| **Chair involved** | |  |  |  | |  | |  | Appropriate height *Yes*   No | | | | |
| Cushion / pillow on chair | |  |  |  | |  | |  |  | | | | |
| Wheelchair | |  |  |  | |  | |  |  | | | | |
| Brakes in use | |  |  |  | |  | |  |  | | | | |
| Falls Alarm (clip and cord) | |  |  |  | |  | |  | Appropriate for patient *Yes*   No | | | | |
| Attached to patient correctly | |  |  |  | |  | |  |  | | | | |
| Sensor pad chair/bed | |  |  |  | |  | |  |  | | | | |
| Functioning/working | |  |  |  | |  | |  | Connected *Yes*   No | | | | |
| Alarm Activated | |  |  |  | |  | |  |  | | | | |
| Assistance alert wristband | |  |  |  | |  | |  |  | | | | |
| Hip protectors | |  |  |  | |  | |  |  | | | | |
| Anti-slip mats/netting | |  |  |  | |  | |  |  | | | | |
| Other orthotic equipment | |  |  |  | |  | |  |  | | | | |
| **S** – Shoes / footwear | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| Was the patient wearing appropriate footwear | |  |  |  | |  | |  | Patient own  antislip socks  bare feet  anti-embolic stockings  bandages | | | | |
| **H** – Hypotension (postural drop) | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| Was Lying and sitting/standing blood pressure recorded in last 7 days / since admission | |  |  |  | |  | |  |  | | | | |
| Postural drop detected | |  |  |  | |  | |  |  | | | | |
| Medication reviewed | |  |  |  | |  | |  |  | | | | |
| Dehydrated | |  |  |  | |  | |  |  | | | | |
| **Post Fall Care** | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| Neurological observations recorded? | |  |  |  | |  | |  | Following nice guidelines *Yes*   No | | | | |
| Was patient checked for injury | |  |  |  | |  | |  |  | | | | |
| Every 30 minutes for first 2 hours? | |  |  |  | |  | |  |  | | | | |
| Evidence of GCS dropping? | |  |  |  | |  | |  |  | | | | |
| Appropriate escalation? | |  |  |  | |  | |  |  | | | | |
| Radiology requested | |  |  |  | |  | |  | CT head  X-ray  Any delays | | | | |
| Discussion with KCH neuroscience? | |  |  |  | |  | |  |  | | | | |
| Post fall checklist completed? | |  |  |  | |  | |  | Full  Partially  Nurse  Doctor | | | | |
| Nurse tab completed on EPR? | |  |  |  | |  | |  |  | | | | |
| Doctor tab completed on EPR? | |  |  |  | |  | |  |  | | | | |
| Safe manual handling post fall | |  |  |  | |  | |  | Hover Jack  Assistance  Scoop  Stood independently | | | | |
| Imaging request escalated? | |  |  |  | |  | |  |  | | | | |
| Appropriate orthopaedic referral? | |  |  |  | |  | |  |  | | | | |
| Surgery in appropriate time frame? | |  |  |  | |  | |  |  | | | | |
| Action taken to prevent further falls? | |  |  |  | |  | |  | Footwear  Equipment  Moved to observable bed | | | | |
| **Assessments** | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| Current falls risk assessment? | |  |  |  | |  | |  | On admission  In the last 7 days  Post fall | | | | |
| Risks identified correctly? | |  |  |  | |  | |  |  | | | | |
| Correct Datix reporting? | |  |  |  | |  | |  |  | | | | |
| MUST score/Nutritional Risk | |  |  |  | |  | |  | If scored over 2 was a dietetic referral completed *Yes*   No | | | | |
| Staffing | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| Did staffing meet establishment requirements | |  |  |  | |  | |  | *If no what is the vacancy and sickness rate* | | | | |
| Did the patient required enhanced care | |  |  |  | |  | |  | *Level 3*  *Level 4* | | | | |
| If yes was enhanced care shifts filled | |  |  |  | |  | |  | *If no did this impact on staff ability to provide CRASH and falls prevention care Yes*   No | | | | |
| Agency staff | |  |  |  | |  | |  |  | | | | |
| Bank staff | |  |  |  | |  | |  |  | | | | |
| Substantive staff | |  |  |  | |  | |  |  | | | | |
| Distractions and interruptions | |  |  |  | |  | |  | Poorly patient  Cardiac arrest | | | | |
| Work area design | |  |  |  | |  | |  | Eg distance from the sluice | | | | |
| Staff received falls training in past year? | |  |  |  | |  | |  |  | | | | |
| Handover/safety huddles | |  |  |  | |  | |  |  | | | | |
| Communication Involving patient/patient transfers | |  |  |  | |  | |  |  | | | | |
| Organisational | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| Day shift | |  |  |  | |  | |  | Time: | | | | |
| Night shift | |  |  |  | |  | |  | Time: | | | | |
| Week day | |  |  |  | |  | |  |  | | | | |
| Week end | |  |  |  | |  | |  |  | | | | |
| Patient/family involved in care? | |  |  |  | |  | |  |  | | | | |
| Environmental | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| Was the patient fall from the toilet | |  |  |  | |  | |  | Toilet seat riser  Grab rails | | | | |
| Fall from bed / stretcher / Trolley / Cot | |  |  |  | |  | |  |  | | | | |
| Fall from Chair | |  |  |  | |  | |  |  | | | | |
| Fall on level ground | |  |  |  | |  | |  |  | | | | |
| Unknown found on floor | |  |  |  | |  | |  |  | | | | |
| Commode | |  |  |  | |  | |  |  | | | | |
| Brakes used and working | |  |  |  | |  | |  |  | | | | |
| Toileting schedule in place | |  |  |  | |  | |  |  | | | | |
| General environment | |  |  |  | |  | |  |  | | | | |
| Appropriate bed assignment | |  |  |  | |  | |  |  | | | | |
| Lighting | |  |  |  | |  | |  |  | | | | |
| Floor condition (wet, shiny, contrast, uneven) | |  |  |  | |  | |  | wet | | | | |
| Furniture placement adequate | |  |  |  | |  | |  |  | | | | |
| Room to move freely/turn radius | |  |  |  | |  | |  |  | | | | |
| **Patient Factor** | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| Pain | |  |  |  | |  | |  |  | | | | |
| Appropriate pain tool used | |  |  |  | |  | |  |  | | | | |
| Neuromuscular | |  |  |  | |  | |  |  | | | | |
| Orthopaedic | |  |  |  | |  | |  |  | | | | |
| Cardiovascular | |  |  |  | |  | |  |  | | | | |
| Recent condition change | |  |  |  | |  | |  |  | | | | |
| Dialysis | |  |  |  | |  | |  |  | | | | |
| Dementia | |  |  |  | |  | |  |  | | | | |
| Delirium | |  |  |  | |  | |  | 4AT above 4 *Yes*   No | | | | |
| Neurological (not dementia) | |  |  |  | |  | |  |  | | | | |
| Alcohol | |  |  |  | |  | |  |  | | | | |
| Surgical procedure | |  |  |  | |  | |  |  | | | | |
| Mental Health | |  |  |  | |  | |  |  | | | | |
| Depression | |  |  |  | |  | |  |  | | | | |
| Other | |  |  |  | |  | |  |  | | | | |
| Cognition | |  |  |  | |  | |  | AMTS score | | | | |
| Eyesight/Visual field | |  |  |  | |  | |  |  | | | | |
| Clothing | |  |  |  | |  | |  |  | | | | |
| Mobility issues | |  |  |  | |  | |  | Amputee  Equipment | | | | |
| Fear of falling | |  |  |  | |  | |  |  | | | | |
| Hearing | |  |  |  | |  | |  |  | | | | |
| Prosthesis/Splint | |  |  |  | |  | |  |  | | | | |
| Language barrier | |  |  |  | |  | |  |  | | | | |
| Behavioural problems/issues | |  |  |  | |  | |  |  | | | | |
| Sensory impairment | |  |  |  | |  | |  |  | | | | |
| Continence issues | |  |  |  | |  | |  | Catheter  Urgency  UTI | | | | |
| Other ie End of Life/Palliative | |  |  |  | |  | |  |  | | | | |
| Bone Health | | | | | | | | | | | | | |
| History of fragility fracture? | |  |  |  | |  | |  |  | | | | |
| Known osteoporosis | |  |  |  | |  | |  | On medication *Yes*   No  Taken correctly *Yes*   No | | | | |
| BMI<19kg/m2 | |  |  |  | |  | |  |  | | | | |
| Other bone health risk factors? | |  |  |  | |  | |  | Steroids *Yes*   No | | | | |
| Sepsis | | | | | | | | | | | | | |
| Known sepsis? | |  |  |  | |  | |  |  | | | | |
| Treated | |  |  |  | |  | |  |  | | | | |
| Deteriorating patient | |  |  |  | |  | |  |  | | | | |
| **Emergency Department Specific Not applicable to this incident** | | Yes | No | N/A | | No Info | | Contributory Factor | If ‘CF to Fall’, explain: | | | | |
| Falls risk assessment completed? | |  |  |  | |  | |  |  | | | | |
| Care plan activated? | |  |  |  | |  | |  |  | | | | |
| Handover provided including falls risk? | |  |  |  | |  | |  |  | | | | |
| Concerns with flow? | |  |  |  | |  | |  |  | | | | |
| Other? | |  |  |  | |  | |  |  | | | | |
| **Concerns with care delivery:**  *(Contributing factors)* | | | | | **Please Tick** | | | | | | **Lessons Learnt** | | |
| **C** – Call bell | | | | |  | | | | | |  | | |
| **R** – Review medication  Polypharmacy | | | | |  | | | | | |  | | |
| **A** – Appropriate equipment | | | | |  | | | | | |  | | |
| **S** – Shoes / footwear | | | | |  | | | | | |  | | |
| **H** – Hypotension (postural drop) | | | | |  | | | | | |  | | |
| Post fall care | | | | |  | | | | | |  | | |
| Assessments | | | | |  | | | | | |  | | |
| Staffing | | | | |  | | | | | |  | | |
| Organisational | | | | |  | | | | | |  | | |
| Environment | | | | |  | | | | | |  | | |
| Patient factors | | | | |  | | | | | |  | | |
| ED | | | | |  | | | | | |  | | |
| **Good Practice** | | | | | **Please Tick if good practice found** | | | | | | **Comments** | | |
| **C** – Call bell | | | | |  | | | | | |  | | |
| **R** – Review medication  Polypharmacy | | | | |  | | | | | |  | | |
| **A** – Appropriate equipment | | | | |  | | | | | |  | | |
| **S** – Shoes / footwear | | | | |  | | | | | |  | | |
| **H** – Hypotension (postural drop) | | | | |  | | | | | |  | | |
| Post fall care | | | | |  | | | | | |  | | |
| Assessments | | | | |  | | | | | |  | | |
| Staffing | | | | |  | | | | | |  | | |
| Organisational | | | | |  | | | | | |  | | |
| Environment | | | | |  | | | | | |  | | |
| Patient factors | | | | |  | | | | | |  | | |
| ED | | | | |  | | | | | |  | | |
| **SEIPS framework** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Tools & Technology** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Organisation** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Task** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Person** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **External environment** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Internal environment** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Key Themes** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Clinical recommendations for Learning** | | | | | | | | | | | | | |
| **Linked QIP actions** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Additional actions for key themes** | | | | | | | | | | | | | |
| **Safety recommendation** | **Category** (Fix/improvement/change/further insight) | | | | | | **Person Responsible** | | | **Deadline** | | | **Evidence** |
|  |  | | | | | |  | | | Click here to enter a date. | | |  |
|  |  | | | | | |  | | | Click here to enter a date. | | |  |
|  |  | | | | | |  | | | Click here to enter a date. | | |  |
| **Level of harm** | | | None  Low  Moderate  Severe  Death | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Falls panel date of approval** | | | Name: **Designation**  Date: Click here to enter a date. | | | | | | | | | | |
| Incident on a page will be populated onto a slide and circulated for learning and presenting to PSG | | | | | | | | | | | | | |

**END OF INVESTIGATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Potential impact of Learning Outcome** | **Impact to Patient** | | | | |
| 1  No impact to patient quality of life/ no increase in LOS | 2  Some short term impact to patient/ No increase to LOS | 3  Short to  Mid-term impact/ Increase in LOS | 4  Long term impact to patient quality of life including after discharge/ Increased LOS | 5  Death of patient/ Loss of quality of life |
| 1. No learning identified/Individual learning only |  |  |  |  |  |
| 2. Known theme – Addressed by ongoing improvement work |  |  |  |  |  |
| 3. Known theme – Not under ongoing improvement work. Potential to inform ongoing improvement work |  |  |  |  |  |
| 4. New emerging theme – for review to support improvement work |  |  |  |  |  |
| 5. New theme – requires immediate learning response and improvement work |  |  |  |  |  |
|  | Local Investigation | | | | |
|  | SWARM (Mini toolkit) | | | | |
|  | AAR (Full toolkit) | | | | |
|  | PSII | | | | |

### Appendix 5.2 Falls SWARM

**SWARM (Mini toolkit)**

Inpatient fall

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name** | |  | | | | | | | | **Date of Birth** |  | |
| **NHS Number** | |  | | | | | | | | **Hospital number** |  | |
| **Date of incident** | |  | | | | | | | | **Datix number** |  | |
| **Ward** | |  | | | | | | | | **Level of Harm at time of AAR** |  | |
| **Harm sustained** | |  | | | | | | | | **DOC Status** |  | |
| **After action review Date** | |  | | | | | | | | **Lead of AAR** |  | |
| **Attendees at AAR** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Description of Incident:** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **How is the patient now and Expected outcome** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Causative factors** | | | **Yes** | **no** | | **Contributed to fall tick** | **Comments** | | | | | |
| **CRASH Care bundle** | | | | | | | | | | | | |
| **C** – Call bell | | |  |  | |  |  | | | | | |
| **R** – Review medication  Polypharmacy | | |  |  | |  |  | | | | | |
| **A** – Appropriate equipment | | |  |  | |  |  | | | | | |
| Falls Alarm | | |  |  | |  | **Clip and cord**  **Bed sensor pad**  **Chari sensor pad** | | | | | |
| Assistance alert wristband | | |  |  | |  |  | | | | | |
| Hip Protectors | | |  |  | |  |  | | | | | |
| Walking aids | | |  |  | |  |  | | | | | |
| Ultra Low bed | | |  |  | |  |  | | | | | |
| Correct Chair height | | |  |  | |  |  | | | | | |
| Other | | |  |  | |  |  | | | | | |
| **S** – Shoes / footwear | | |  |  | |  |  | | | | | |
| **H** – Hypotension (postural drop) | | |  |  | |  |  | | | | | |
| **Post fall care** | | | | | | | | | | | | |
| Was patient checked for injury | | |  |  | |  |  | | | | | |
| Safe manual handling post fall | | |  |  | |  | Hover Jack  Assistance  Scoop  Stood independently | | | | | |
| Radiology / CT requested as policy | | |  |  | |  | Any delays | | | | | |
| Post fall checklist completed | | |  |  | |  | Full  Partially  Nurse  Doctor | | | | | |
| Medical review post fall | | |  |  | |  |  | | | | | |
| Neurological observations according to NICE guidance | | |  |  | |  |  | | | | | |
| Incident report completed timely | | |  |  | |  |  | | | | | |
| **Assessments** | | | | | | | | | | | | |
| Falls Risk assessment completed | | |  |  | |  |  | | | | | |
| Bed rail assessment completed | | |  |  | |  |  | | | | | |
| Falls Care plan competed | | |  |  | |  |  | | | | | |
| 4AT completed | | |  |  | |  |  | | | | | |
| **Patient factors** | | | | | | | | | | | | |
| Patient was non-compliant with capacity | | |  |  | |  |  | | | | | |
| Patient was non-compliant without capacity | | |  |  | |  |  | | | | | |
| Mobility Concerns | | |  |  | |  |  | | | | | |
| Previous fall on this admission | | |  |  | |  |  | | | | | |
| Patient inappropriately placed on ward | | |  |  | |  |  | | | | | |
| Symptoms prior to fall | | |  |  | |  |  | | | | | |
| Witnessed fall | | |  |  | |  |  | | | | | |
| Staffing | | | | | | | | | | | | |
| Did staffing meet establishment requirements | | |  |  | |  | *If no what is the vacancy and sickness rate* | | | | | |
| Did the patient required enhanced care | | |  |  | |  | *Level 3*  *Level 4* | | | | | |
| If yes was enhanced care shifts filled | | |  |  | |  | *If no did this impact on staff ability to provide CRASH and falls prevention care Yes*   No | | | | | |
| Organisational | | |  |  | |  |  | | | | | |
| Day shift | | |  |  | |  | Time: | | | | | |
| Night shift | | |  |  | |  | Time: | | | | | |
| Week day | | |  |  | |  |  | | | | | |
| Week end | | |  |  | |  |  | | | | | |
| Environmental | | |  |  | |  |  | | | | | |
| Was the patient fall from the toilet | | |  |  | |  | *If yes is there a causative factor which can inform learning Yes*   No | | | | | |
| Fall from bed / stretcher / Trolley / Cot | | |  |  | |  |  | | | | | |
| Fall from Chair | | |  |  | |  |  | | | | | |
| Fall on level ground | | |  |  | |  | *Lowered to floor* | | | | | |
| Unknown found on floor | | |  |  | |  |  | | | | | |
| Other issues regarding investigation | | |  |  | |  |  | | | | | |
| **Causative Factors** | | | | | **Please Tick if is a causative factor** | | | **Comments** | | | | |
| **C** – Call bell | | | | |  | | |  | | | | |
| **R** – Review medication  Polypharmacy | | | | |  | | |  | | | | |
| **A** – Appropriate equipment | | | | |  | | |  | | | | |
| **S** – Shoes / footwear | | | | |  | | |  | | | | |
| **H** – Hypotension (postural drop) | | | | |  | | |  | | | | |
| Post fall care | | | | |  | | |  | | | | |
| Assessments | | | | |  | | |  | | | | |
| Patient factors | | | | |  | | |  | | | | |
| Staffing | | | | |  | | |  | | | | |
| environmental | | | | |  | | |  | | | | |
| organisational | | | | |  | | |  | | | | |
| **Good Practice** | | | | | **Please Tick if good practice found** | | | **Comments** | | | | |
| **C** – Call bell | | | | |  | | |  | | | | |
| **R** – Review medication  Polypharmacy | | | | |  | | |  | | | | |
| **A** – Appropriate equipment | | | | |  | | |  | | | | |
| **S** – Shoes / footwear | | | | |  | | |  | | | | |
| **H** – Hypotension (postural drop) | | | | |  | | |  | | | | |
| Post fall care | | | | |  | | |  | | | | |
| Assessments | | | | |  | | |  | | | | |
| Patient factors | | | | |  | | |  | | | | |
| Staffing | | | | |  | | |  | | | | |
| environmental | | | | |  | | |  | | | | |
| organisational | | | | |  | | |  | | | | |
| **Key Themes** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Clinical Recommendation’s for learning** | | | | | | | | | | | | |
| **Linked QIP actions** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Additional Actions from Key Themes** | | | | | | | | | | | | |
| **Safety Recommendation** | **Category** (Fix/improvement/change/further insight) | | | **Person responsible** | | | | | **Deadline** | | | **Evidence** |
|  |  | | |  | | | | |  | | |  |
|  |  | | |  | | | | |  | | |  |
|  |  | | |  | | | | |  | | |  |
|  |  | | |  | | | | |  | | |  |
| **Level of Harm** | | None  Low  Moderate  Severe Death | | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Potential impact of Learning Outcome** | **Impact to Patient** | | | | | | 1  No impact to patient quality of life/ no increase in LOS | 2  Some short term impact to patient/ No increase to LOS | 3  Short to  Mid-term impact/ Increase in LOS | 4  Long term impact to patient quality of life including after discharge/ Increased LOS | 5  Death of patient/ Loss of quality of life | | 1. No learning identified/Individual learning only |  |  |  |  |  | | 2. Known theme – Addressed by ongoing improvement work |  |  |  |  |  | | 3. Known theme – Not under ongoing improvement work. Potential to inform ongoing improvement work |  |  |  |  |  | | 4. New emerging theme – for review to support improvement work |  |  |  |  |  | | 5. New theme – requires immediate learning response and improvement work |  |  |  |  |  | |  | Local Investigation | | | | | |  | SWARM (Mini toolkit) | | | | | |  | AAR (Full toolkit) | | | | | |  | PSII | | | | | | | | | | | | | | | | | |
| **Falls panel date of approval** | | Date: Click here to enter a date.  Name:  **Designation:** | | | | | | | | | | |
| Incident on a page will be populated onto a slide and circulated for learning and presenting to PSG | | | | | | | | | | | | |

END OF INVESTIGATION

### Appendix 5.3 TVN AAR

**AFTER ACTION REVIEW (Full toolkit)**

**Hospital Acquired Pressure ulcer**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name** | |  | | | | | | | | **Date of Birth** | | |  | |
| **NHS Number** | |  | | | | | | | | **Hospital number** | | |  | |
| **Date of incident** | |  | | | | | | | | **Datix number** | | |  | |
| **Ward** | |  | | | | | | | | **Level of Harm at time of SWARM** | | |  | |
| **Anatomical Location** | |  | | | | | | | | **Category** | | |  | |
| **Are there multiple Pressure Ulcers** | | **Yes**  **No** | | | | | | | | **DOC Status** | | |  | |
| **Safeguarding referral required** | | **Yes**  **No** | | | | | | | | **Safeguarding toolkit Score:** | | |  | |
| **SWARM Date** | |  | | | | | | | | **Lead of SWARM** | | |  | |
| **Attendees at SWARM** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Description of Incident: (Time line if required)** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **How is the patient now and Expected outcome** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Investigation**  ( **Confirm Yes/No or N/A depending on evidence in notes and if it is a causative factor to the pressure ulcer development)** | | | | | | | | | | | | | | |
| **Assessment** | | | | **Yes** | | **No** | | **N/A** | **Causative factor** | | | **Comments and answer questions** | | |
| Was the patient admitted via ED | | | |  | |  | |  |  | | | *If yes How long was the patient in ED*  *Chair*  *Trolley* | | |
| Was the initial risk and skin assessment completed in ED documentation? | | | |  | |  | |  |  | | | *If no is there any documentation regarding pressure ulcer strategies ie- Patient moved onto a bed* | | |
| **Assessment**  Pressure ulcer risk assessment completed on admission to the ward / area? | | | |  | |  | |  |  | | | *What was the risk assessment Level?*  *At Risk*  *High Risk*  *Very High Risk* | | |
| Was a pressure ulcer risk assessment then completed weekly as per policy or if the patient condition changed? | | | |  | |  | |  |  | | | *What was the risk assessment Level?*  *At Risk*  *High Risk*  *Very High Risk* | | |
| Did the risk assessment correctly identify the risk of the patient developing a pressure ulcer | | | |  | |  | |  |  | | |  | | |
| **Skin** | | | | **Yes** | | **No** | | **N/A** | **Causative factor** | | | **Comments and answer questions** | | |
| Was the patient a long lie prior to admission? | | | |  | |  | |  |  | | | *If so specify in comments how long were they on the floor and what position were they in* | | |
| Did the pressure ulcer acquire within 7 Days of admission | | | |  | |  | |  |  | | |  | | |
| Did the patient have a pressure ulcer on admission? | | | |  | |  | |  |  | | | *Where did this pressure ulcer originate*  *own home  Nursing home*  *Residential home  Other hospital*  *What Category?*  *Size:*  *Anatomical Location:* | | |
| Is it the pressure ulcer inherited that has deteriorates. If so has the change in category and date recorded in the notes? | | | |  | |  | |  |  | | |  | | |
| Skin assessment completed on admission to ward / area? | | | |  | |  | |  |  | | |  | | |
| Is there evidence of RN skin assessments daily within the medical notes / electronic patient record? | | | |  | |  | |  |  | | |  | | |
| Has the reposition and ASSKIN care plan been completed once a day by RN? | | | |  | |  | |  |  | | |  | | |
| **Surface** | | | | **Yes** | | **No** | | **N/A** | **Causative factor** | | | **Comments and answer questions** | | |
| Was an appropriate mattress used in line with the waterlow or skin assessment following the Trust pathways? | | | |  | |  | |  |  | | | *What mattress was in place?*  *Invacare  Dolphin*  *Invacare with Pump  Turncair 1000*  *Aria* | | |
| Was an appropriate cushion in use in line with the waterlow or skin assessment following the Trust pathway? | | | |  | |  | |  |  | | | *What mattress was in place?*  *Invacare  Dolphin*  *Invacare with Pump  Turncair 1000*  *Aria* | | |
| Was appropriate heel prevention used in line with skin assessment following the Trust pathways? | | | |  | |  | |  |  | | | *What heel Prevention was used?*  *Foam Boots*  *Heel Lifts*  *Other* | | |
| If patient was receiving O2 therapy is there appropriate evidence that mepitac tape or Kerrapro Strips was used ? | | | |  | |  | |  |  | | |  | | |
| Was the mattress ordered via Equipment services? | | | |  | |  | |  |  | | |  | | |
| Was the mattress ordered via Call a porter? | | | |  | |  | |  |  | | |  | | |
| Were there any delays in the in ordering or receiving the mattress? | | | |  | |  | |  |  | | |  | | |
| Were there any functional failings with mattress? | | | |  | |  | |  |  | | |  | | |
| Was there a delay in transferring the patient onto the mattress at ward level? | | | |  | |  | |  |  | | | *If so how long* | | |
| Was there a delay in ordering or receiving of blue heel lifts? | | | |  | |  | |  |  | | |  | | |
| Was there a delay in ordering or receiving Foam boots or procedure pads? | | | |  | |  | |  |  | | |  | | |
| Was specialist equipment advised by TVN? | | | |  | |  | |  |  | | | *If yes specify in comment’s – ie dolphin,*  *turn care mattress etc* | | |
| Was the Pressure Ulcer caused by a Medical device | | | |  | |  | |  |  | | | *If yes state what device caused the damage?* | | |
| Is there evidence that the skin was inspected under and round medical devices twice a day as a minimum? | | | |  | |  | |  |  | | |  | | |
| Was the Pressure Ulcer caused by a Medical device | | | |  | |  | |  |  | | | *If yes state what device caused the damage?* | | |
| If the HAPU was on the heel Does the patient have any vascular problems? | | | |  | |  | |  |  | | | *If yes state ABPI or other vascular specialist opinions and how the condition is managed?* | | |
| Was heel prevention used from admission knowing the patient had vascular concerns | | | |  | |  | |  |  | | | *Comment on what heel prevention.* | | |
| Was the heel prevention stepped up following the pressure ulcer pathway? | | | |  | |  | |  |  | | | *Comment on what heel prevention.* | | |
| **Keep Moving** | | | | **Yes** | | **No** | | **N/A** | **Causative factor** | | | **Comments and answer questions** | | |
| Appropriate mobility/turning/repositioning in place following Trust pathways? | | | |  | |  | |  |  | | | *Reposition regime?*  *1 Hourly  2 Hourly*  *3 Hourly  4 Hourly* | | |
| Was a reposition and ASSKIN care bundle initiated as per policy? | | | |  | |  | |  |  | | |  | | |
| Were the repositions consistent? | | | |  | |  | |  |  | | |  | | |
| **Incontinence** | | | | **Yes** | | **No** | | **N/A** | **Causative factor** | | | **Comments and answer questions** | | |
| Was patient continent before admission? | | | |  | |  | |  |  | | |  | | |
| Was the Patient incontinent of Urine? | | | |  | |  | |  |  | | |  | | |
| Was patient catheterised? | | | |  | |  | |  |  | | |  | | |
| Was the Patient incontinent of Faeces? | | | |  | |  | |  |  | | |  | | |
| Was a flexi seal or other faecal management system used or considered? | | | |  | |  | |  |  | | |  | | |
| Were incontinence pads used? | | | |  | |  | |  |  | | | *What attends were used*  *4  6  8* | | |
| Is there documentation to state they were changed regularly? | | | |  | |  | |  |  | | |  | | |
| Was a IAD score recorded ? | | | |  | |  | |  |  | | | *IAD Score*  *0*  *1-Mild  2-Moderate  3-Severe* | | |
| Were barrier products consistent and in line with SMART pathway? | | | |  | |  | |  |  | | | *Treatment used*  *Derma Cream*  *Derma Spray*  *Medi Derma Pro* | | |
| Was this evidenced on the reposition chart? | | | |  | |  | |  |  | | |  | | |
| Were the application consistently recorded? | | | |  | |  | |  |  | | |  | | |
| Did the patient have MASD? | | | |  | |  | |  |  | | | *If yes was this*  IAD  ID  ITD | | |
| Was this reported on Datix? | | | |  | |  | |  |  | | | *WEB* | | |
| Is the HAPU a combination lesion | | | |  | |  | |  |  | | |  | | |
| WAS masd managed correctly | | | |  | |  | |  |  | | | *If no is this what lead to the HAPU deterioration? Yes*   No | | |
| **Nutrition** | | | | **Yes** | | **No** | | **N/A** | **Causative factor** | | | **Comments and answer questions** | | |
| Was a nutritional assessment (weight & MUST) carried out within 72 hours of admission? | | | |  | |  | |  |  | | | *What was the MUST score?*  0  1  2  3 | | |
| Were the results acted upon? | | | |  | |  | |  |  | | | Dietician referral  Food chart  Red Tray  Nothing | | |
| Was a nutritional assessment (weight & MUST) evaluated weekly? | | | |  | |  | |  |  | | |  | | |
| Were there changes in the MUST score | | | |  | |  | |  |  | | | *What was the MUST score?*  0  1  2  3 | | |
| Were the results acted upon? | | | |  | |  | |  |  | | | Dietician referral  Food chart  Red Tray  Nothing | | |
| Was the nutritional intake recorded fully as required? | | | |  | |  | |  |  | | | *If yes is there evidence of this* | | |
| Was the patients diet adequate | | | |  | |  | |  |  | | |  | | |
| Dietary intake had an impact on the wound healing? | | | |  | |  | |  |  | | |  | | |
| Was Fluid balance monitored as required? | | | |  | |  | |  |  | | | *If yes is there evidence of this* | | |
| Were regular assessments carried out by the dietician? | | | |  | |  | |  |  | | |  | | |
| **Giving Information** | | | | **Yes** | | **No** | | **N/A** | **Causative factor** | | | **Comments and answer questions** | | |
| Are there pressure ulcer leaflets available on the ward for patient information? | | | |  | |  | |  |  | | |  | | |
| Are there pressure ulcer passports available on the ward for patient information, if identified as having a pressure ulcer? | | | |  | |  | |  |  | | |  | | |
| Was there evidence in the notes to say patient was given verbal information/education about pressure ulcers? | | | |  | |  | |  |  | | |  | | |
| **Wound Management** | | | | **Yes** | | **No** | | **N/A** | **Causative factor** | | | **Comments and answer questions** | | |
| Was a wound assessment completed and recorded on the Wound management care plan on the electronic patient records? | | | |  | |  | |  |  | | |  | | |
| Was the wound management care plan updated at dressing changed or a minimum of twice a week on the electronic patient records? | | | |  | |  | |  |  | | |  | | |
| Was the dressing used, followed by the wound dressing formulary guide? | | | |  | |  | |  |  | | |  | | |
| Does the patient have any other type of wound or skin condition that may have contributed to the incident? | | | |  | |  | |  |  | | |  | | |
| Were the tissue viability recommendations for dressings followed? | | | |  | |  | |  |  | | |  | | |
| Staffing | | | | | | | | | | | | | | |
| Did staffing meet establishment requirements for up to 72 hours prior to acquisition | | | |  | |  | |  |  | | | *If no what is the vacancy and sickness rate* | | |
| Did the patient required enhanced care | | | |  | |  | |  |  | | | *Level 3*  *Level 4* | | |
| If yes was enhanced care shifts filled | | | |  | |  | |  |  | | | *If no did this impact on staff ability to provide ASSKING care Yes*   No | | |
| **Organisational** | | | | **Yes** | | **No** | | **N/A** | **Causative factor** | | | **Comments and answer questions** | | |
| **Mobility and Manual Handling** | | | | | | | | | | | | | | |
| Was repositioning the patient difficult due to critical care/ haemodynamic/ spinal instability/ end of life needs/ pain or refusal by patient? | | | |  | |  | |  |  | | | *If yes specify in comment’s* | | |
| Is there evidence to state that slide sheets were used to move and handle the patient? | | | |  | |  | |  |  | | | *If yes specify in comment’s* | | |
| **Referrals** | | | | | | | | | | | | | | |
| If pressure ulcer was on the heel (or below malleolus) was a podiatry referral completed? | | | |  | |  | |  |  | | | *Date completed*  *Date seen* | | |
| Was a referral to the Tissue Viability nurses completed? | | | |  | |  | |  |  | | | *Date completed*  *Date seen* | | |
| Was a referral to Dietetics completed? | | | |  | |  | |  |  | | | *Date completed*  *Date seen* | | |
| If appropriate was a referral done to Physio? | | | |  | |  | |  |  | | | *Date completed*  *Date seen* | | |
| If appropriate was a referral done to OT? | | | |  | |  | |  |  | | | *Date completed*  *Date seen* | | |
| If appropriate was a referral done to Wheelchair services? | | | |  | |  | |  |  | | | *Date completed*  *Date seen* | | |
| Were any other referrals that were needed completed? | | | |  | |  | |  |  | | | *For example Diabetes, Infection Control, Surgical Team….*  *Date completed*  *Date seen* | | |
| **Reporting** | | | | | | | | | | | | | | |
| Has the Pressure ulcer had a DATIX raised? | | | |  | |  | |  |  | | |  | | |
| Incident has been raised on STEIS as per policy? | | | |  | |  | |  |  | | |  | | |
| Pressure ulcers were reported by the ward accountable for the deterioration? | | | |  | |  | |  |  | | |  | | |
| Patient the harm validated by the Tissue viability Nurse? | | | |  | |  | |  |  | | |  | | |
| **Team**  **Not applicable to this care** | | | | | | | | | | | | | | |
| Were the Medical / Surgical Team aware of the pressure damage? | | | |  | |  | |  |  | | | *If yes is there evidence of this?* | | |
| Concern of care delivery outside of scope of PU management | | | |  | |  | |  |  | | | *Details needed* | | |
| **Patient Factors** | | | | **Yes** | | **No** | | **N/A** | **Causative factor** | | | **Comments and answer questions** | | |
| **Patient Compliance**  **Not applicable to this care** | | | | | | | | | | | | | | |
| Is there evidence in the notes to suggest that the patient was non-concordant with pressure ulcer prevention and management? | | | |  | |  | |  |  | | |  | | |
| Is there evidence that the patient had a capacity assessment completed? | | | |  | |  | |  |  | | |  | | |
| **IF PATIENT HAS CAPACITY**  Was a pressure ulcer leaflet/passport given for them to make an informed decision? | | | |  | |  | |  |  | | |  | | |
| **IF PATIENT DOESN’T HAVE CAPACITY**  Was a Tissue Viability Nurse referral completed? | | | |  | |  | |  |  | | |  | | |
| **IF PATIENT DOESN’T HAVE CAPACITY**  Did abest interest meeting take place? | | | |  | |  | |  |  | | |  | | |
| **Pain**  **Not applicable to this care** | | | | | | | | | | | | | | |
| Did the patient experience pain? | | | |  | |  | |  |  | | | *What was the pain score?* | | |
| Was the pain description and score regularly assessed? | | | |  | |  | |  |  | | | *If yes, Where* | | |
| Was the pain managed appropriately | | | |  | |  | |  |  | | |  | | |
| If patient lacked the ability to express pain was the cognitive pain assessment used? | | | |  | |  | |  |  | | |  | | |
| Is the patient refusing to be repositioned due to pain? | | | |  | |  | |  |  | | |  | | |
| **Diabetic Management**  **Not applicable to this care** | | | | | | | | | | | | | | |
| If patient was diabetic was the blood glucose monitoring maintained? | | | |  | |  | |  |  | | | *If no did patient suffer with Hypo’s/hyper’s* | | |
| **End Of life Care**  **Not applicable to this care** | | | | | | | | | | | | | | |
| During the admission did the patient go onto the end of life care pathway? | | | |  | |  | |  |  | | |  | | |
| Was patient on End of Life Care Pathway at time of acquisition | | | |  | |  | |  |  | | |  | | |
| Was the pressure ulcer acquired within 2 weeks of death? | | | |  | |  | |  |  | | | *If yes was the pressure ulcer on the sacrum* | | |
| Was the pressure ulcer identified within 6 weeks of death? | | | |  | |  | |  |  | | | *If yes was this end of life SCALE (skin changes at life’s end)* | | |
| Did TVN diagnose this as SCALE? | | | |  | |  | |  |  | | |  | | |
| **Neurological**  **Not applicable to this care** | | | | | | | | | | | | | | |
| Did the patient have cognitive impairment? (dementia) | | | |  | |  | |  |  | | | *Describe any specific needs.* | | |
| Was the “This is me “document completed? If the patient had dementia | | | |  | |  | |  |  | | |  | | |
| Does the patient have mental health issues or learning disability? | | | |  | |  | |  |  | | |  | | |
| Was the patient confused or suffering delirium? | | | |  | |  | |  |  | | |  | | |
| If yes was the 4AT score completed? | | | |  | |  | |  |  | | |  | | |
| Was the patient refusing pressure ulcer prevention strategies? | | | |  | |  | |  |  | | |  | | |
| Is there evidence in the notes to suggest a capacity assessment was completed? | | | |  | |  | |  |  | | |  | | |
| Is the patients level on consciousness a factor in ability to reposition | | | |  | |  | |  |  | | |  | | |
| **Deteriorating patient**  **Not applicable to this care** | | | | | | | | | | | | | | |
| News score monitored | | | |  | |  | |  |  | | |  | | |
| Was patient diagnosed with Sepsis secondary to wound infection? | | | |  | |  | |  |  | | |  | | |
| Is the use of ANTT evidenced as being used when carrying out wound care? | | | |  | |  | |  |  | | |  | | |
| Were anti-microbial dressings considered and was this documented on the wound care plan? | | | |  | |  | |  |  | | | *Which dressing was used* | | |
| Was this evidenced in the Medical Notes by the team? | | | |  | |  | |  |  | | | *Date completed* | | |
| Was the pressure ulcer swabbed? | | | |  | |  | |  |  | | | *Date completed*  *Was it positive* | | |
| **Medication**  **Not applicable to this care** | | | | | | | | | | | | | | |
| Was the patient on any type of medication which could contribute to the development of pressure ulcers? | | | |  | |  | |  |  | | | *Such as; Inotropes, steroids, anticoagulants, vasoconstrictors* | | |
| **Overview of causative factors** | | | | | | | | | | | | | | |
| **Themes** | | | **Please Tick if causative factors found** | | | | **Comments** | | | | | | | |
| Assessment | | |  | | | |  | | | | | | | |
| Skin | | |  | | | |  | | | | | | | |
| Surface | | |  | | | |  | | | | | | | |
| Keep Moving | | |  | | | |  | | | | | | | |
| Incontinence | | |  | | | |  | | | | | | | |
| Nutrition | | |  | | | |  | | | | | | | |
| Giving Information | | |  | | | |  | | | | | | | |
| Wound management | | |  | | | |  | | | | | | | |
| Staffing | | |  | | | |  | | | | | | | |
| Organisational | | |  | | | |  | | | | | | | |
| Patient factors | | |  | | | |  | | | | | | | |
| **Good Practice** | | | **Please Tick if good practice found** | | | | **Comments** | | | | | | | |
| Assessment | | |  | | | |  | | | | | | | |
| Skin | | |  | | | |  | | | | | | | |
| Surface | | |  | | | |  | | | | | | | |
| Keep Moving | | |  | | | |  | | | | | | | |
| Incontinence | | |  | | | |  | | | | | | | |
| Nutrition | | |  | | | |  | | | | | | | |
| Giving Information | | |  | | | |  | | | | | | | |
| Wound management | | |  | | | |  | | | | | | | |
| Staffing | | |  | | | |  | | | | | | | |
| Organisational | | |  | | | |  | | | | | | | |
| Patient factors | | |  | | | |  | | | | | | | |
| **SEIPS framework** | | | | | | | | | | | | | | |
| **Tools & Technology** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Organisation** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Task** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Person** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **External environment** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Internal environment** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Key Themes** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Clinical Recommendation’s for learning** | | | | | | | | | | | | | | |
| **Linked QIP actions** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Additional Actions from Key Themes** | | | | | | | | | | | | | | |
| **Safety recommendation** | **Category** (Fix/improvement/change/further insight) | | | | **Person Responsible** | | | | | | **Deadline** | | | **Evidence** |
|  |  | | | |  | | | | | | Click here to enter a date. | | |  |
|  |  | | | |  | | | | | | Click here to enter a date. | | |  |
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|  |  |
| --- | --- |
| **Level of Harm** | None  Low  Moderate  Severe Death |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Potential impact of Learning Outcome** | **Impact to Patient** | | | | | | 1  No impact to patient quality of life/ no increase in LOS | 2  Some short term impact to patient/ No increase to LOS | 3  Short to  Mid-term impact/ Increase in LOS | 4  Long term impact to patient quality of life including after discharge/ Increased LOS | 5  Death of patient/ Loss of quality of life | | 1. No learning identified/Individual learning only |  |  |  |  |  | | 2. Known theme – Addressed by ongoing improvement work |  |  |  |  |  | | 3. Known theme – Not under ongoing improvement work. Potential to inform ongoing improvement work |  |  |  |  |  | | 4. New emerging theme – for review to support improvement work |  |  |  |  |  | | 5. New theme – requires immediate learning response and improvement work |  |  |  |  |  | |  | Local Investigation | | | | | |  | SWARM (Mini toolkit) | | | | | |  | AAR (Full toolkit) | | | | | |  | PSII | | | | | | |
| **Pressure ulcer panel date of approval** | Date: Click here to enter a date.  Name:  **Designation:** |
| Incident on a page will be populated onto a slide and circulated for learning and presenting to PSG | |

### Appendix 5.4 TVN SWARM

**SWARM (Mini toolkit)**

Hospital Acquired Pressure Ulcer

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name** |  | | | | | | **Date of Birth** | | | | |  | |
| **NHS Number** |  | | | | | | **Hospital number** | | | | |  | |
| **Date of incident** |  | | | | | | **Datix number** | | | | |  | |
| **Ward** |  | | | | | | **Level of Harm at time of AAR** | | | | |  | |
| **Anatomical Location** |  | | | | | | **Category** | | | | |  | |
| **Are there multiple Pressure Ulcers** | **Yes**  **No** | | | | | | **DOC Status** | | | | |  | |
| **Safeguarding referral required** | **Yes**  **No** | | | | | | **Safeguarding toolkit Score:** | | | | |  | |
| **After action review Date** |  | | | | | | **Lead of AAR** | | | | |  | |
| **Attendees at AAR** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Description of Incident:** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **How is the patient now and Expected outcome** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Investigation**  ( **Confirm Yes/No or N/A depending on evidence in notes and if it contributed to the pressure ulcer development)** | | | | | | | | | | | | | |
| **Assessment** | | | | **Yes** | **No** | **N/A** | | **Contributed** | | **Comments and answer questions** | | | |
| Was the patient admitted via ED | | | |  |  |  | |  | | *If yes How long was the patient in ED*  *Chair*  *Trolley* | | | |
| Was the initial risk and skin assessment completed in ED documentation? | | | |  |  |  | |  | | *If no is there any documentation regarding pressure ulcer strategies ie- Patient moved onto a bed* | | | |
| **Assessment**  Pressure ulcer risk assessment completed on admission to the ward / area? | | | |  |  |  | |  | | *What was the risk assessment Level?*  *At Risk*  *High Risk*  *Very High Risk* | | | |
| Was a pressure ulcer risk assessment then completed weekly as per policy or if the patient condition changed? | | | |  |  |  | |  | | *What was the risk assessment Level?*  *At Risk*  *High Risk*  *Very High Risk* | | | |
| Did the risk assessment correctly identify the risk of the patient developing a pressure ulcer | | | |  |  |  | |  | |  | | | |
| **Skin** | | | | **Yes** | **No** | **N/A** | | **Contributed** | | **Comments and answer questions** | | | |
| Did the patient have a pressure ulcer on admission? | | | |  |  |  | |  | | *Where did this pressure ulcer originate*  *own home  Nursing home*  *Residential home  Other hospital*  *What Category?*  *Size:*  *Anatomical Location:* | | | |
| Is it the pressure ulcer inherited that has deteriorates. If so has the change in category and date recorded in the notes? | | | |  |  |  | |  | |  | | | |
| Skin assessment completed on admission to ward / area? | | | |  |  |  | |  | |  | | | |
| Is there evidence of RN skin assessments daily within the medical notes / electronic patient record? | | | |  |  |  | |  | |  | | | |
| Has the reposition and ASSKIN care plan been completed once a day by RN? | | | |  |  |  | |  | |  | | | |
| **Surface** | | | | **Yes** | **No** | **N/A** | | **Contributed** | | **Comments and answer questions** | | | |
| Was an appropriate mattress used in line with the waterlow or skin assessment following the Trust pathways? | | | |  |  |  | |  | | *What mattress was in place?*  *Invacare  Dolphin*  *Invacare with Pump  Turncair 1000*  *Aria* | | | |
| Was an appropriate cushion in use in line with the waterlow or skin assessment following the Trust pathway? | | | |  |  |  | |  | | *What mattress was in place?*  *Invacare  Dolphin*  *Invacare with Pump  Turncair 1000*  *Aria* | | | |
| Was appropriate heel prevention used in line with skin assessment following the Trust pathways? | | | |  |  |  | |  | | *What heel Prevention was used?*  *Foam Boots*  *Heel Lifts*  *Other* | | | |
| If patient was receiving O2 therapy is there appropriate evidence that mepitac tape or Kerrapro Strips was used ? | | | |  |  |  | |  | |  | | | |
| Was the Pressure Ulcer caused by a Medical device | | | |  |  |  | |  | | *If yes state what device caused the damage?* | | | |
| If yes Is there evidence that the skin was inspected under and round medical devices twice a day as a minimum? | | | |  |  |  | |  | |  | | | |
| If the HAPU was on the heel Does the patient have any vascular problems? | | | |  |  |  | |  | | *If yes state ABPI or other vascular specialist opinions and how the condition is managed?* | | | |
| Was heel prevention used from admission knowing the patient had vascular concerns | | | |  |  |  | |  | | *Comment on what heel prevention.* | | | |
| Was the heel prevention stepped up following the pressure ulcer pathway? | | | |  |  |  | |  | | *Comment on what heel prevention.* | | | |
| **Keep Moving** | | | | **Yes** | **No** | **N/A** | | **Contributed** | | **Comments and answer questions** | | | |
| Appropriate mobility/turning/repositioning in place following Trust pathways? | | | |  |  |  | |  | | *Reposition regime?*  *1 Hourly  2 Hourly*  *3 Hourly  4 Hourly* | | | |
| Was a reposition and ASSKIN care bundle initiated as per policy? | | | |  |  |  | |  | |  | | | |
| Were the repositions consistent? | | | |  |  |  | |  | |  | | | |
| **Incontinence** | | | | **Yes** | **No** | **N/A** | | **Contributed** | | **Comments and answer questions** | | | |
| Was patient continent before admission? | | | |  |  |  | |  | |  | | | |
| Was the Patient incontinent of Urine? | | | |  |  |  | |  | |  | | | |
| Was patient catheterised? | | | |  |  |  | |  | |  | | | |
| Was the Patient incontinent of Faeces? | | | |  |  |  | |  | |  | | | |
| Was a flexi seal or other faecal management system used or considered? | | | |  |  |  | |  | |  | | | |
| Were incontinence pads used? | | | |  |  |  | |  | | *What attends were used*  *4  6  8* | | | |
| Is there documentation to state they were changed regularly? | | | |  |  |  | |  | |  | | | |
| Did the patient have MASD? | | | |  |  |  | |  | | *If yes was this*  IAD  ID  ITD | | | |
| Was a IAD score recorded ? | | | |  |  |  | |  | | *IAD Score*  *0*  *1-Mild  2-Moderate  3-Severe* | | | |
| Were barrier products consistent and in line with SMART pathway? | | | |  |  |  | |  | | *Treatment used*  *Derma Cream*  *Derma Spray*  *Medi Derma Pro* | | | |
| Was this evidenced on the reposition chart? | | | |  |  |  | |  | |  | | | |
| Were the application consistently recorded? | | | |  |  |  | |  | |  | | | |
| Is the HAPU a combination lesion | | | |  |  |  | |  | |  | | | |
| WAS masd managed correctly | | | |  |  |  | |  | | *If no is this what lead to the HAPU deterioration? Yes*   No | | | |
| **Nutrition** | | | | **Yes** | **No** | **N/A** | | **Contributed** | | **Comments and answer questions** | | | |
| Was a nutritional assessment (weight & MUST) carried out within 72 hours of admission? | | | |  |  |  | |  | | *What was the MUST score?*  0  1  2  3 | | | |
| Were the results acted upon? | | | |  |  |  | |  | | Dietician referral  Food chart  Red Tray  Nothing | | | |
| Was a nutritional assessment (weight & MUST) evaluated weekly? | | | |  |  |  | |  | |  | | | |
| Were there changes in the MUST score | | | |  |  |  | |  | | *What was the MUST score?*  0  1  2  3 | | | |
| Were the results acted upon? | | | |  |  |  | |  | | Dietician referral  Food chart  Red Tray  Nothing | | | |
| Was the nutritional intake recorded fully as required? | | | |  |  |  | |  | | *If yes is there evidence of this* | | | |
| Was the patients diet adequate | | | |  |  |  | |  | |  | | | |
| Dietary intake had an impact on the wound healing? | | | |  |  |  | |  | |  | | | |
| Was Fluid balance monitored as required? | | | |  |  |  | |  | | *If yes is there evidence of this* | | | |
| Were regular assessments carried out by the dietician? | | | |  |  |  | |  | |  | | | |
| **Giving Information** | | | | **Yes** | **No** | **N/A** | | **Contributed** | | **Comments and answer questions** | | | |
| Are there pressure ulcer leaflets available on the ward for patient information? | | | |  |  |  | |  | |  | | | |
| Are there pressure ulcer passports available on the ward for patient information, if identified as having a pressure ulcer? | | | |  |  |  | |  | |  | | | |
| Was there evidence in the notes to say patient was given verbal information/education about pressure ulcers? | | | |  |  |  | |  | |  | | | |
| **Wound Management** | | | | **Yes** | **No** | **N/A** | | **Contributed** | | **Comments and answer questions** | | | |
| Was a wound assessment completed and recorded on the Wound management care plan on the electronic patient records? | | | |  |  |  | |  | |  | | | |
| Was the wound management care plan updated at dressing changed or a minimum of twice a week on the electronic patient records? | | | |  |  |  | |  | |  | | | |
| Was the dressing used, followed by the wound dressing formulary guide? | | | |  |  |  | |  | |  | | | |
| Were the tissue viability recommendations for dressings followed? | | | |  |  |  | |  | |  | | | |
| Staffing | | | | | | | | | | | | | |
| Did staffing meet establishment requirements for up to 72 hours prior to acquisition | | | |  |  |  | |  | | *If no what is the vacancy and sickness rate* | | | |
| Did the patient required enhanced care | | | |  |  |  | |  | | *Level 3*  *Level 4* | | | |
| If yes was enhanced care shifts filled | | | |  |  |  | |  | | *If no did this impact on staff ability to provide ASSKING care Yes*   No | | | |
| **Organisational** | | | | **Yes** | **No** | **N/A** | | **Contributed** | | **Comments and answer questions** | | | |
| **Mobility and Manual Handling** | | | | | | | | | | | | | |
| Was repositioning the patient difficult due to critical care/ haemodynamic/ spinal instability/ end of life needs/ pain or refusal by patient? | | | |  |  |  | |  | | *If yes specify in comment’s* | | | |
| Was a referral to the Tissue Viability nurses completed? | | | |  |  |  | |  | | *Date completed*  *Date seen* | | | |
| Concern of care delivery outside of scope of PU management | | | |  |  |  | |  | | *Details needed* | | | |
| **Patient factors** | | | | **Yes** | **No** | **N/A** | | **Contributed** | | **Comments and answer questions** | | | |
| **Patient Compliance**  **Not applicable to this care** | | | | | | | | | | | | | |
| Is there evidence in the notes to suggest that the patient was non-concordant with pressure ulcer prevention and management? | | | |  |  |  | |  | |  | | | |
| Is there evidence that the patient had a capacity assessment completed? | | | |  |  |  | |  | |  | | | |
| **IF PATIENT HAS CAPACITY**  Was a pressure ulcer leaflet/passport given for them to make an informed decision? | | | |  |  |  | |  | |  | | | |
| **IF PATIENT DOESN’T HAVE CAPACITY**  Was a Tissue Viability Nurse referral completed? | | | |  |  |  | |  | |  | | | |
| **IF PATIENT DOESN’T HAVE CAPACITY**  Did abest interest meeting take place? | | | |  |  |  | |  | |  | | | |
| **Pain Not applicable to this care** | | | |  |  |  | |  | |  | | | |
| Is the patient refusing to be repositioned due to pain? | | | |  |  |  | |  | |  | | | |
| **Diabetic Management**  **Not applicable to this care** | | | | | | | | | | | | | |
| If patient was diabetic was the blood glucose monitoring maintained? | | | |  |  |  | |  | | *If no did patient suffer with Hypo’s/hyper’s* | | | |
| **End Of life Care**  **Not applicable to this care** | | | | | | | | | | | | | |
| During the admission did the patient go onto the end of life care pathway? | | | |  |  |  | |  | |  | | | |
| Was patient on End of Life Care Pathway at time of acquisition | | | |  |  |  | |  | |  | | | |
| **Neurological**  **Not applicable to this care** | | | | | | | | | | | | | |
| Did the patient have cognitive impairment? (dementia) | | | |  |  |  | |  | | *Describe any specific needs.* | | | |
| Was the “This is me “document completed? If the patient had dementia | | | |  |  |  | |  | |  | | | |
| Does the patient have mental health issues or learning disability? | | | |  |  |  | |  | |  | | | |
| Was the patient confused or suffering delirium, | | | |  |  |  | |  | |  | | | |
| If yes was the 4AT score completed? | | | |  |  |  | |  | |  | | | |
| Was the patient refusing pressure ulcer prevention strategies? | | | |  |  |  | |  | |  | | | |
| **Deteriorating patient**  **Not applicable to this care** | | | | | | | | | | | | | |
| News score monitored | | | |  |  |  | |  | |  | | | |
| Was patient diagnosed with Sepsis secondary to wound infection? | | | |  |  |  | |  | |  | | | |
| **Medication**  **Not applicable to this care** | | | | | | | | | | | | | |
| Was the patient on any type of medication which could contribute to the development of pressure ulcers? | | | |  |  |  | |  | | *Such as; Inotropes, steroids, anticoagulants, vasoconstrictors* | | | |
| **Causative Factors** | | | **Please Tick if is a causative factor** | | | | | | | | **Comments** | | |
| Assessment | | |  | | | | | | | |  | | |
| Skin | | |  | | | | | | | |  | | |
| Surface | | |  | | | | | | | |  | | |
| Keep Moving | | |  | | | | | | | |  | | |
| Incontinence | | |  | | | | | | | |  | | |
| Nutrition | | |  | | | | | | | |  | | |
| Giving Information | | |  | | | | | | | |  | | |
| Wound management | | |  | | | | | | | |  | | |
| Staffing | | |  | | | | | | | |  | | |
| Organisational | | |  | | | | | | | |  | | |
| Patient factors | | |  | | | | | | | |  | | |
| **Good Practice** | | | **Please Tick if good practice found** | | | | | | | | **Comments** | | |
| Assessment | | |  | | | | | | | |  | | |
| Skin | | |  | | | | | | | |  | | |
| Surface | | |  | | | | | | | |  | | |
| Keep Moving | | |  | | | | | | | |  | | |
| Incontinence | | |  | | | | | | | |  | | |
| Nutrition | | |  | | | | | | | |  | | |
| Giving Information | | |  | | | | | | | |  | | |
| Wound management | | |  | | | | | | | |  | | |
| Staffing | | |  | | | | | | | |  | | |
| Organisational | | |  | | | | | | | |  | | |
| Patient factors | | |  | | | | | | | |  | | |
| **Key Themes** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Clinical Recommendation’s for learning** | | | | | | | | | | | | | |
| **Linked QIP actions** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Additional Actions from Key Themes** | | | | | | | | | | | | | |
| **Safety Recommendation** | | **Category** (Fix/improvement/change/further insight) | | | | | | | **Person responsible** | | **Deadline** | | **Evidence** |
|  | |  | | | | | | |  | | Click here to enter a date. | |  |
|  | |  | | | | | | |  | | Click here to enter a date. | |  |
|  | |  | | | | | | |  | | Click here to enter a date. | |  |
|  | |  | | | | | | |  | | Click here to enter a date. | |  |
| **Level of Harm** | None  Low  Moderate  Severe Death | | | | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Potential impact of Learning Outcome** | **Impact to Patient** | | | | | | 1  No impact to patient quality of life/ no increase in LOS | 2  Some short term impact to patient/ No increase to LOS | 3  Short to  Mid-term impact/ Increase in LOS | 4  Long term impact to patient quality of life including after discharge/ Increased LOS | 5  Death of patient/ Loss of quality of life | | 1. No learning identified/Individual learning only |  |  |  |  |  | | 2. Known theme – Addressed by ongoing improvement work |  |  |  |  |  | | 3. Known theme – Not under ongoing improvement work. Potential to inform ongoing improvement work |  |  |  |  |  | | 4. New emerging theme – for review to support improvement work |  |  |  |  |  | | 5. New theme – requires immediate learning response and improvement work |  |  |  |  |  | |  | Local Investigation | | | | | |  | SWARM (Mini toolkit) | | | | | |  | AAR (Full toolkit) | | | | | |  | PSII | | | | | | | | | | | | | | | | | | |
| **Pressure ulcer panel date of approval** | Date: Click here to enter a date.  Name:  **Designation:** | | | | | | | | | | | | |
| Incident on a page will be populated onto a slide and circulated for learning and presenting to PSG | | | | | | | | | | | | | |

**END OF INVESTIGATION**

## Appendix 6 – PSII Template

Patient safety incident investigation (PSII) report

**On completion of your final report, please ensure you have deleted all the blue information boxes and green text.**

|  |
| --- |
| **Notes on the PSII template**  This national template is designed to improve the recording and standardisation of PSII reports and facilitate national collection of findings for learning purposes. This format will continue to be evaluated and developed by the National Patient Safety Team.  **General writing tips**  A PSII report must be accessible to a wide audience and make sense when read on its own. The report should:   * use clear and simple everyday English whenever possible * explain or avoid technical language * use lists where appropriate * keep sentences short. |

|  |  |
| --- | --- |
| Incident ID number: |  |
| Date incident occurred: |  |
| Report approved date: |  |
| Approved by: |  |

# Distribution list

**List who will receive the final draft and the final report (eg patients/relatives/staff involved¸ board). Remove names prior to distribution.**

|  |  |
| --- | --- |
| Name | Position |
|  |  |
|  |  |

# About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation’s systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine ‘system factors’ such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the [Engaging and involving patients, families and staff after a patient safety guidance](https://www.england.nhs.uk/patient-safety/incident-response-framework/) in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the [Just Culture guide](https://www.england.nhs.uk/patient-safety/a-just-culture-guide/) in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the [Patient Safety Incident Response Framework](https://www.england.nhs.uk/patient-safety/incident-response-framework/) and in the national [patient safety incident response standards](https://www.england.nhs.uk/patient-safety/incident-response-framework/).

# A note of acknowledgement

|  |
| --- |
| **Notes on writing a note of acknowledgement**  In this brief section you should thank the patient whose experience is documented in the report along with contributions from their family and others (including carers, etc) who gave time and shared their thoughts.  You could consider referring to the patient by name or as ‘the patient’ according to their wishes.  Also thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements. |

# Executive summary

|  |
| --- |
| **Notes on writing the executive summary**  To be completed **after the main report has been written.** |

## **Incident overview**

|  |
| --- |
| **Notes on writing the incident overview for the executive summary**  Add a brief, plain English description of the incident here. |

## **Summary of key findings**

|  |
| --- |
| **Notes on writing the summary of key findings for the executive summary**  Add a brief overview of the main findings here (potentially in bullet point form). |

## **Summary of areas for improvement and safety actions**

|  |
| --- |
| **Notes on writing about areas for improvement and safety actions for the executive summary**  Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan.  Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.  Areas for improvement and safety actions must be written to stand alone, in plain English and without abbreviations.  Refer to the [Safety action development guide](https://www.england.nhs.uk/patient-safety/incident-response-framework/) for further details on how to write safety actions.  NB: The term ‘lesson learned’ is no longer recommended for use in PSIIs. |

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# Background and context

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| **Notes on writing about background and context**  The purpose of this section, where appropriate, is to provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist understanding of the incident. It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.  It may also be worth using this section to summarise any key national standards or local policies/guidelines that are central to the investigation. |

# Description of the patient safety incident

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| **Notes on writing a description of the event**  The purpose of this section is to describe the patient safety incident. It should not include any analysis of the incident or findings – these come later.  Think about how best to structure the information – eg by day or by contact with different services on the care pathway.  It should be written in neutral language, eg ‘XX asked YY’ not ‘YY did not listen to XX’. Avoid language such as ‘failure’, ‘delay’ and ‘lapse’ that can prompt blame.  If the patient or family/carer has agreed, you could personalise the title of this section to ‘[NAME]’s story/experience’. |

# Investigation approach

## **Investigation team**

|  |  |  |  |
| --- | --- | --- | --- |
| **Role** | **Initials** | **Job title** | **Dept/directorate and organisation** |
| **Investigation commissioner/convenor:** |  |  |  |
| **Investigation lead:** |  |  |  |

## **Summary of investigation process**

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| **Notes on writing about the investigation process**  If useful, you should include a short paragraph outlining the investigation process:   * how the incident was reported (e.g. via trust reporting system) * how agreement was reached to investigate (e.g. review of patient safety incident response plan, panel review, including titles of panel members) * what happened when the investigation was complete (e.g. final report approved by whom)? * how actions will be monitored. |

## **Terms or reference**

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| **Notes on writing about scope**  In this section you should describe any agreed boundaries (that is, what is in and out of scope) for the investigation. For example, you might want to note:   * the aspects of care to be covered by the investigation * questions raised by the those affected that will be addressed by the investigation   If those affected by the patient safety incident (patients, families, carers and staff) agree, they should be involved in setting the terms of reference as described in the [Engaging and involving patients, families and staff after a patient safety incident guidance](https://www.england.nhs.uk/patient-safety/incident-response-framework/).  A template is available in the learning response toolkit to help develop terms of reference. |

## **Information gathering**

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| **Notes on writing about information gathering**  The purpose of this section is to provide a short overview of your investigation approach. You should include a brief overview of your methods including:   * investigation framework and any analysis methods used. Remember to keep jargon to a minimum (e.g. the investigation considered how factors such as the environment, equipment, tasks and policies influenced the decisions and actions of staff) * interviews with key participants (including the patient/family/carer) * observations of work as done * documentation reviews, e.g. medical records, staff rosters, guidelines, SOPs * any other methods.   Recorded reflections, e.g. those used for learning portfolios, revalidation or continuing professional development purposes, are **not suitable** sources of evidence for a systems-focused PSII.  Statements are not recommended. Interviews and other information gathering approaches are preferred. |

# Findings

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| **Notes on writing your findings**  The purpose of this section is to summarise your analysis of the information you have gathered and to state the findings you have drawn from that analysis.  You may choose to include diagrams and/or tables to communicate your analytical reasoning and findings.  Do not re-tell the story in the description of the patient safety incident. This section is about the ‘how’ the incident happened, not the ‘what’ and ‘when’.  Start with an introductory paragraph that describes the purpose of the section and structure you are going to use.  For your findings to have impact you will need to communicate them in a clear and logical way. Before you start, think about how best to structure the section, then make a plan.  You may find sub-headings useful. The structure you choose will depend on your investigation, but you could organise the information as follows:   * by the themes you have identified during the investigation – in which case put your strongest theme first * following the framework or the analytical method you used * in chronological order corresponding to the care pathway described in the reference event, e.g. community care, ambulance service, acute care (taking care not to repeat the story of the reference event) * in order of the main decision points during the incident.   Use clear, direct language, e.g., ‘The investigation found…’  If the section is long and contains multiple sub-sections, consider adding a summary of key points at the end of each sub-section.  Technical terms should be kept to an absolute minimum. If they are required, you should explain them in the text (glossaries should be avoided).  **Include your defined areas for improvement and safety actions (where appropriate) in the relevant places in this section.**  Areas for improvement that describe broader systems issues related to the wider organisation context are best addressed in a safety improvement plan. You should describe what the next stages are with regards to developing a safety improvement plan that will include meaningful actions for system improvement. |

# Summary of findings, areas for improvement and safety actions

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| **Notes on writing the final summary**  The purpose of this section is to bring together the main findings of the investigation.  Areas for improvement and associated safety actions (if applicable) should be listed using the table provided (also available in Appendix B of the [safety action development guide](https://www.england.nhs.uk/patient-safety/incident-response-framework/)).  If no actions are identified the safety action summary table is not required. Instead you should describe how the areas for improvement will be addressed (e.g. refer to other ongoing improvement work, development of a safety improvement plan) |

## **Safety action summary table**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Area for improvement: [eg r*eview of test results*]** | | | | | | | | |
|  | **Safety action description**  ***(SMART)*** | **Safety action owner**  ***(role, team directorate)*** | **Target date for implementation** | **Date Implemented** | **Tool/measure** | **Measurement frequency**  ***(e.g. daily, monthly)*** | **Responsibility for monitoring/ oversight**  ***(E.g. specific group/ individual, etc.)*** | **Planned review date**  ***(e.g. annually)*** |
| 1. |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |
| … |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Area for Improvement: [eg *nurse-to-nurse handover*]** | | | | | | | | |
|  | **Safety action description**  ***(SMART)*** | **Safety action owner**  ***(role, team directorate)*** | **Target date for implementation** | **Date Implemented** | **Tool/measure** | **Measurement frequency**  ***(e.g. daily, monthly)*** | **Responsibility for monitoring/ oversight**  ***(E.g. specific group/ individual, etc.)*** | **Planned review date**  ***(e.g. annually)*** |
| 1. |  |  |  |  |  |  |  |  |
| … |  |  |  |  |  |  |  |  |

# Appendices

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| **Notes on appendices**  Include any necessary additional details such as explanatory text, tables, diagrams, etc (Delete this section if there are none). |

# References

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| **Notes on references**  Include references to national and local policy/procedure/guidance, and other data sources as required. |

**END OF INVESTIGATION**

## Appendix 7 – Standard Local Quality Improvement Action Plan

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| --- | --- | --- | --- | --- |
| **Safety recommendation** | **Category** (Fix/improvement/change/further insight) | **Person Responsible** | **Deadline** | **Evidence** |
|  |  |  |  |  |
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|  |  |  |  |  |
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| --- | --- | --- |
| Category | Definition | Example |
| ***Fix*** | Resolve problems in reliably doing what we said we would do. These were usually issues that could be resolved with rapid operational changes. | Linear or more ‘simple’ things you can do to help the process. E.g., if you identify that there are conflicting local policies which meant a clinician was confused with the task, then the **fix** would be to resolve the confusion by rewriting the policy |
| ***Improvements*** | Find better ways of delivering standard care; improve what is currently being done. | Where improvement need to be made in an already defined process. This may be linked to a Quality Improvement (QI) project and should involve metrics to measure improvements. |
| ***Changes*** | Significant changes in clinical or operational practice. | Where a system, process, or pathway needs to change. N.b. this should be based on multiple cases of evidence, rather than being linked to one case. Where change is needed, an output may be a task and finish group, and this will involve multiple stakeholders. |
| ***Further insight*** | Where investigations have resulted in more questions relating to a safety issue, it may be appropriate for a safety recommendation to involve gaining more insight | If you do an investigation for a particular safety risk but are not sure of the scale of the problem or the mechanism of action then collecting further data may then help identify safety recommendations later. |

## Appendix 8 – Equality Impact Assessment Screening Tool

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| Is there any evidence that some groups are affected differently? (use the screening below) |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Protected Characteristic | Could there be an adverse impact?  Yes/No/  Unknown | Relevance  None/Low/  Medium/High | Proportionality (likelihood of risk/impact) | | Notes |
| None/Low/  Med/High | +ve / -ve |
| Age | No | None | None |  | n/a |
| Disability | No | None | None |  | n/a |
| Gender / Sex | No | None | None |  | n/a |
| Gender Identity | No | None | None |  | n/a |
| Race | No | None | None |  | n/a |
| Religion/Belief | No | None | None |  | n/a |
| Sexual Orientation | No | None | None |  | n/a |
| Pregnancy & Maternity | No | None | None |  | n/a |
| Marriage / Civil Partnership | No | None | None |  | n/a |

|  |  |  |
| --- | --- | --- |
| Questions | | |
| 1 | Does the proposal … |  |
| a | * promote equality of opportunity? | Yes |
| b | * eliminate unlawful discrimination? | Yes |
| c | * good community relations? | Yes |
| d | * amount to illegal discrimination? | No |
| e | * create an inequality? | No |

|  |  |  |
| --- | --- | --- |
| 2 | If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?  Is the impact of the case likely to be negative and if so can the impact be mitigated?  Can we reduce the impact by taking different action: what alternatives are there to achieving the aim? | N/A |

1. Unless the death falls under another more specific category within the Nationally-defined incidents requiring local PSII, in which case that response must be followed. [↑](#footnote-ref-2)