

Patient safety incident response plan

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Introduction

This patient safety incident response plan sets out how Orr Medical intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

We are accountable for our failures as well as our success and will not allocate blame. We aim to improve our approach to the incidents we investigate. Our approach will involve investigating multiple incidents related to a particular focus area. This approach will be divided into two areas:

- Responsiveness (responding to incidents that occur and cause harm)
- Focus areas (areas for potential learning that fit the criteria stated below, enabling us to explore and understand in greater depth over a 12-month period)

This plan will help us measurably improve the efficacy of our local patient safety incident investigations.

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

The aim of this approach is to continually improve. As such this document will be reviewed annually.



Our services

Orr Medical delivers a remote triage service to the population of Preston, Chorley and South Ribble in Lancashire.



Defining our patient safety incident profile

Orr Medical serves a population of around 165,000 people across a catchment area covering Preston, Chorley and South Ribble.

We provide a remote triage service for GP Practices and their respective patients.

We review the referral forms and letters sent from GP practices to tier 2, secondary and tertiary care for a limited number of specialities, to ensure that they are directed to the correct clinic with the correct level of urgency. We also check that all the required information has been included by the referrer and that the patient is following the locally agreed pathway. We also apply evidenced based intervention policies and apply prior approval codes to those referrals meeting the policy criteria. All of these actions are to ensure that the patient is seen in the correct place at the correct time with all the necessary information available to the assessing clinician.

Our services are delivered through clinically led and managerially enabled services. This enables Orr Medical to focus on putting people first.

A key part of developing Orr Medical's PSIRP is understanding in detail our Patient Safety Profile and the activity that is associated with it. Identifying and understanding our Patient Safety Profile support us to effectively plan to ensure we have the right processes, systems, and resources in place to deliver our Patient Safety Incident Response plan.

To-date Orr Medical have never reported any patient safety incidents since the inception of the triage service over 4 years ago.

Defining our patient safety improvement profile

Orr Medical does not provide direct patient services, we are a remote 'back office' type function. We have not reported any patient safety incidents since the inception of the Triage Contract with ourselves and do not envisage doing so due to the nature of the contract that we hold.

As per our policy, should we start to report any patient safety incidents, we will identify any common themes and report on them to our Commissioners as required. We will then take the learning from these incidents to ensure that future incidents are avoided in the future.

Whilst reviewing any common themes, we will involve all parties and stakeholders, ensuring that learning and teaching can be cascaded to all the relevant parties involved.

Possible Response Types:

- Response Type Description Patient Safety Event Investigation (PSII)
 - A patient safety event investigation (PSII) will be undertaken when an event or near-miss indicates significant patient safety risks and potential for new learning in line with the national priorities (see below). Investigations explore decisions or actions as they relate to the situation.
- After Action Review
 - An After Action Review (AAR) is 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 failure and promote success for the future.
- Being Open Discussion
 - To provide the opportunity for a verbal discussion about the event (what happened) and respond to any concerns Event Timeline An event timeline is a complete real-time record of an even

Our patient safety incident response plan: national requirements

In addition to local priorities there are several patient safety events that fall within the national priority areas. These include:

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Deaths thought more likely than not due to problems in care(incident meeting the learning from investigations)	PSII	We would cooperate with any investigation or inquest taking place and disseminate any learning.
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).	Lead organisation to do PSII	We would cooperate with any investigation or inquest taking place and disseminate any learning.
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Lead organisation to do PSII	We are not involved in any maternity, antenatal or postnatal care, but would participate in any enquiry should it be necessary.

<p>HSSIB will investigate the following maternity safety incidents;</p> <ul style="list-style-type: none"> • Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life. • Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days). • Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was therapeutically cooled (active cooling only); or – had decreased central tone, was comatose and had seizures of any kind. • • Maternal deaths: death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides). 		
<p>Mental health related homicide</p>	<p>Lead organisation to do PSII</p>	<p>We would cooperate with any investigation or inquest taking place and disseminate any learning.</p>

Death of persons with learning disabilities or Autism	Lead organisation to do PSII	We would cooperate with any investigation or inquest taking place and disseminate any learning.
Deaths in custody	Lead organisation to do PSII	We would cooperate with any investigation or inquest taking place and disseminate any learning.
Child Death	Lead organisation to do PSII	We would cooperate with any investigation or inquest taking place and disseminate any learning.
<p>Safeguarding Events in which:</p> <ul style="list-style-type: none"> babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence adults (over 18 years old) are in receipt of care and support needs from their local authority the event relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence 	Lead organisation to do PSII	<p>Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards</p> <p>We would cooperate with any investigation or inquest taking place and disseminate any learning.</p>
Incidents in screening programmes	Lead organisation to do PSII	We are not involved with any type of screening programmes, but would participate in any enquiries.

Our patient safety incident response plan: local focus

There are a wide range of responses that can be deployed when a patient safety event occurs. The decision on the appropriate response for each event, will be informed by this plan.

Apart from the national criteria for PSII, the decision to carry out a patient safety incident investigation should be based on whether the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

The type of response will also depend on:

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