NHS
Kent and Medway
NHS and Social Care Partnership Trust

Patient Safety Incident Response Plan

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Author	Emily Headley, Central Investigation Team Manager	0.1 draft – Mar 2024 0.2 & 0.3 amended and updated – Jun 2024 0.4 reviewed, approved and submitted – Jul 2024 (v1) 0.5 minor updates – Aug 2024 (v1.1) 0.6 minor updates – Sept 2024 (v1.2) 0.7 minor updates – Sept 2024 (v1.3) 0.8 minor updates – Oct 2024 (v1.4) 0.9 final draft – Oct 2024 (v2) 1.0 final – Oct 2024
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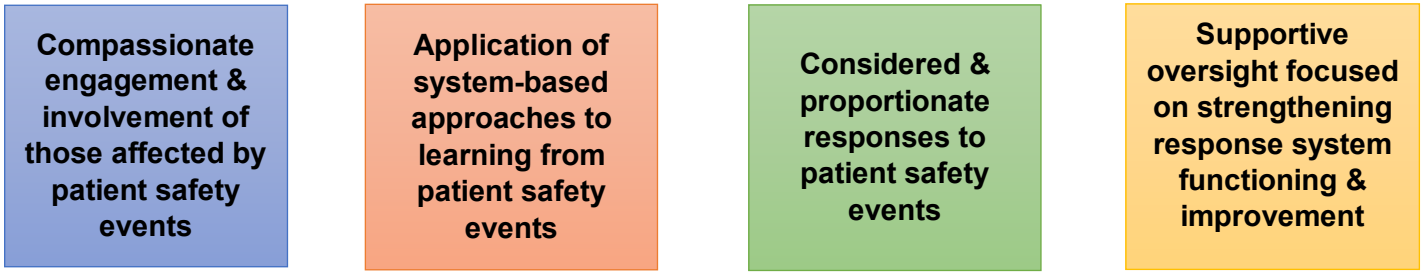
With thanks to Annie Oakley for her work on a draft

Contents

1. Introduction

NHS England (NHSE) has developed a new national strategy for learning from patient safety events, called the Patient Safety Incident Response Framework (known as PSIRF). This sets out that organisations should describe their overall approach to responding to and learning from patient safety events, for improvement and identify the systems and processes in place to integrate the four key aims of PSIRF:



This Patient Safety Incident Response Plan (PSIRP) describes how Kent and Medway NHS and Social Care Partnership Trust (KMPT, or 'the trust') will respond to patient safety events in accordance with the PSIRF from September 2024. The plan is a live document that can be changed as practice evolves and becomes embedded. We will remain flexible and consider the specific circumstances in which patient safety issues and events occurred, the needs of those affected, and take a proportionate response that is fair and promotes a just, learning culture.

The trust will review patient safety information regularly through governance and safety meetings, providing updates to the workstreams within the plan. The plan will initially be reviewed at 6 months locally, then with the commissioners at 12 months, and at least annually after that to ensure the plan is current and proving effective in learning and improving.

We have aligned our plan to the KMPT strategic ambitions. The trust ambitions include:

- We deliver outstanding, person-centred care that is safe, high quality and easy to access
- We are a great place to work and have engaged and capable staff, living our values
- Partners we work with: We lead in partnership to deliver the right care and to reduce health inequalities in our communities

For more information on PSIRF, please see the NHS England PSIRF information webpage and/or this short, animated video which provides an overview of PSIRF.

2. Objectives

This plan will help us improve our response to local patient safety events by:

- Enhancing the systems approach within Patient Safety Incident Investigations (PSIIs) and learning responses, which takes account of how multiple factors interact together
- Promoting a fair, just and learning culture. We will act on feedback from staff about concerns regarding patient safety events and improve the support for staff involved in learning responses. We will have a good involvement with staff within investigations, and continue to use the Just Culture approach within PSIIs. Staff will be signposted to internal and external support sources
- Focusing on addressing factors with the use of improvement methods, plan-do-study-act cycles, and auditing to prevent or continuously reduce repeat patient safety risks and events
- Moving the emphasis from the quantity of PSIIs to quality, to ensure the continuous improvement of patient safety through learning from events and improvement methodology
- Ensuring an improved experience for patients, their families and carers whenever a patient safety event occurs or when a PSII is required. We will do this by acting on feedback from these groups, and also from staff when they raise concerns. We will support and involve patients and families or carers in the learning responses to better understand how events have occurred, and by the continued promotion of Duty of Candour and compassionate engagement
- Working to have an improved integrated approach to the response and improvements to patient safety incidents by the development of an organisational-led integrated approach with all commissioners[1] who commission services within KMPT
- Learning from good care

[1] Commissioners throughout this plan relate to all organisations who commission KMPT services (Kent, Surrey and Sussex Provider Collaborative, Kent and Medway Integrated Care Board and NHS England).

- Having an improved, central base for historical and current improvement plans which are monitored, and linked with learning from PSIIs, complaints, local learning and national learning. This will also be a central base for learning from good practice too

3. Scope

This process is specific to patient safety event responses conducted solely for the purpose of learning and improvement across the services that we provide. This document describes how we will respond to different types of events and how we will work with commissioners and other organisations around patient safety events and learning from these events.

There are different methods for learning from events and this relates to the systems approach for improvement. The trust will use both a centralised and directorate approach to investigation, with PSIIs being completed by a team sitting outside of the clinical services. This will ensure an independent and neutral investigation, alongside the involvement of the clinical and leadership teams to inform a well-rounded investigative approach, in line with systems-based methodology.

This plan will also consider the learning methodology and how learning is embedded. Response types that are outside the scope of this plan will be included in the PSIRF policy.

4. Our Services

Our trust provides a wide range of adult mental health and learning disability services to our local population of 1.8 million people in Kent and Medway, as well as specialist services for adults in Sussex and Surrey. Each year we care for over 2,000 people in our hospitals and 54,000 people in the community.

We employ over 3,700 people from 66 nationalities, to serve an increasingly diverse range of communities across rural and urban areas.

We are part of the Kent and Medway Integrated Care System, a partnership of organisations that come together to plan and deliver joined-up health and care services to improve the lives of people across Kent and Medway.

We provide a range of mental health services as well as some non-mental health services. Some of these are community mental health services, inpatient services, rehabilitation services, perinatal services, dementia services, and forensic services. We care for people from 18 years old, except within the Early Intervention in Psychosis service (when services begin at age 14), the Mother and Baby Unit (who take patients from any age), and the Liaison, Diversion and Reconnect service (who support people from age 10).

Clinical services at the trust are grouped into directorates. Each directorate is led by a clinical director, a practising clinician who is supported by a head of nursing and a service director. The five directorates are:

1. **Acute:** inpatient wards within three hospitals and other satellite units, places of safety, electro-convulsive therapy, psychiatric intensive care unit and liaison

2. **East Kent:** community mental health teams, community mental health service for older persons, hospital liaison, early intervention in psychosis, rehabilitation service, community rehabilitation, crisis home treatment and rapid response teams, East Kent rapid dementia transfer service, specialist personality disorder

3. **West Kent:** community mental health teams, community mental health service for older persons, hospital liaison, rehabilitation service, specialist personality disorder, crisis home treatment and rapid response teams

4. **North Kent:** community mental health teams, community mental health service for older persons, hospital liaison, early intervention in psychosis, rehabilitation service, community rehabilitation, crisis home treatment and rapid response teams

5. **Forensic and Specialist:** neuropsychiatry, neuropsychology, forensic outreach and liaison, low secure service, medium secure service, liaison, diversion and reconnect service, mental health of learning disabilities, perinatal mental health community service, addiction service, specialist equipment service, chronic fatigue service, community brain injury team, offender personality disorder pathway, veterans covenant healthcare alliance

5. Defining our patient safety incident profile

We have developed strong governance processes across the directorates and the corporate patient safety team. We continue to review our governance processes to ensure that: they remain fit for purpose, patient safety is the focus, and there remains an ongoing process of effective learning and continuous improvement within a fair and just culture. Additionally, we continue to embrace national and regional guidance and support from NHS organisations, regulators, commissioners and partner agencies.

The trust Quality Committee will retain oversight of quality improvement measures and safety improvement plans to ensure they remain of the highest standard. Its sub-committee, the Trust Wide Patient Safety and Mortality Review Group, will ensure that the clinical and corporate directorates provide robust assurance to learning and safety improvement plans, confirming that the process of embedded learning from PSIRF continues. The Quality Committee will ensure that the clinical and corporate divisions provide robust assurance to quality improvement, in accordance with the KMPT Quality Account Priorities.

Initially, a working group was set up consisting of governance leads, mortality review manager, and learning and development leads, led by the head of patient safety, before requesting a review by other groups. Sub-groups emerged, relating to the plan itself and to the education required. The patient safety partner was involved following the development of the first draft of the plan.

Stakeholder engagement

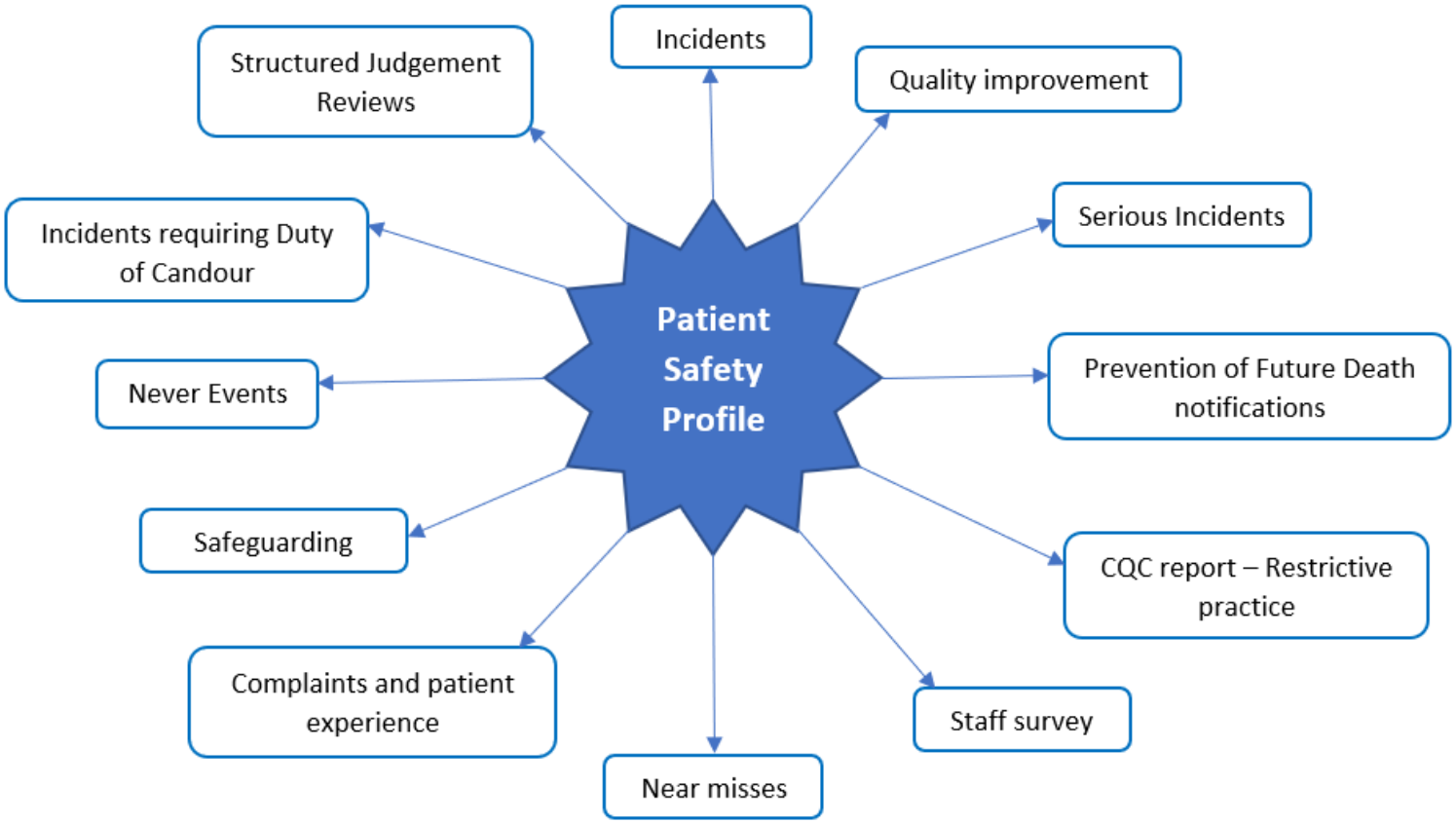
The following have been involved in reviewing this document:

Executive Board	Quality Committee	Trust-Wide Patient Safety and Morality Review Group
Patient Experience Group	Patient safety partner	Each directorate governance group & leadership team
Patient safety team	Matrons	CQC Oversight Group
PALS & complaints team	Information governance	Human resources
Physical health team	Medicines Management Group	Safeguarding team

The following have contributed to the data:

Directorate governance leads	Legal services	Human resources business partner
PALS & complaints manager	Improvement team	Promoting safer services manager
Patient safety team, including patient experience data analyst and morality review manager		

The following data from 2021/22 through to 2023/24 was collected and reviewed:



Incident data reviewed

The table below shows the incident data that was reviewed:

Never Events
Serious Incidents (unrelated to death) (See additional data below)
Serious Incidents resulting in death (this was not broken down further as this will still be a requirement under the PSIRF process)
Patient safety incidents (not Serious Incidents) requiring Duty of Candour
Patient safety incidents which were not Serious Incidents (excluding medication incidents)
Staff on patient allegations of abuse cases reported as Serious incidents
Medication incidents
Self-harm (excluding ligatures)
Self-harm (ligatures)

**These categories changed in March 2023 due to the move from reporting incidents on Datix to InPhase*

Other data collected between 2021 and March 2024

Data	Summary of findings	Improvements
Prevention of Future Death (PFD) notifications	We received 6 PFDs, with the themes being: • Handover of patient between providers did not include medication advice. Issues relating to capacity to make specific decisions in relation to a patient's care and treatment were not all subjected to formal Mental Capacity Act assessments when a patient refused medical interventions • Use of acronyms which were not understood • There was no evidence of a multi-agency planning meeting prior to discharge	To continue to respond in accordance with Regulation 28 requirements by developing actions and sharing learning. Actions are monitored until they have been met/closed. To continue to monitor any existing open actions and align to existing plans and programmes and to develop additional improvement plans in line with PSIRF.

Data	Summary of findings	Improvements
	• Carer breakdown is likely to have increased the risks of suicidality on discharge as this was not addressed during the hospital admission nor on discharge • No policy for KMPT and the Approved Mental Health Practitioner (AMHP) service to communicate when application of the Mental Health Act (MHA) is required • Staff shortage prevented reallocation of a patient after the patient and care coordinator relationship broke down	
Structured Judgement Reviews (SJRs)	Consistent themes relating to good practice between 2021 and 2024 were: • Physical health checks (mostly for patients who are prescribed an antipsychotic, intramuscular injection or oral medication) • Communication with external care providers, including social services, General Practitioners and other agencies • Documentation, including MDT meetings, detail of appointments, rationale for decision making, or documenting the plan of care • Follow up with the patient including face to face contact, missed appointments, or delays in follow up	Changes that have been made as a result of SJRs are: • Linking in with physical health work ongoing within the trust. Training has been held with staff around ECG recording • Communication with families and carers has been added as a priority to our suicide prevention approach • Communications has been shared for various learning points, including safeguarding, and communication with external services • A small proportion of SJRs were referred for a root cause analysis (RCA) review due to identified gaps in care. Actions such as DVT detection and

Data	Summary of findings	Improvements
		monitoring on a ward, autism care provision and drug and alcohol support have been put in place to prevent recurrence A Learning from Deaths Steering Group is being set up to support mortality reviews and improved engagement with the SJR process.
Staff survey	The NHS National Staff survey helps us to determine as a trust the areas of priority to support, retain and grow our workforce. The 2022 staff survey identified the following areas in relation to improving patient safety: • Staff feeling confident that the organisation would address concerns about unsafe clinical practice • Ensuring there are enough staff for individuals to do their job properly • The organisation acting on concerns raised by patients/service users. • Feeling that the organisation would address any concerns individuals raised The most recent staff survey is being reviewed.	To enhance job satisfaction and support recruitment the trust has a number improvement workstreams in place including the following: • Local recruitment plans • Apprenticeship programmes • Equality, diversity and inclusion strategy • Staff health and wellbeing strategy • Just culture • SEIPS
Near misses	We identified low numbers of near miss reporting, with 13 near misses reported between December 2022 and December 2023.	Educate staff in what constitutes a ‘near miss’ through PSIRF training and learning events Promote a Safety-II approach to better understand reported ‘near miss’ data

Data	Summary of findings	Improvements
		To replace the term *'near miss'* with *'good catch'*
Duty of Candour	Duty of Candour data has shown us that whilst we are good at engaging in an open and transparent way both verbally and in writing with patients and families, the timeliness of initial communications can be improved.	Ensure regular communication and engagement is maintained with all those affected by a patient safety incident. We will continue to deliver Duty of Candour training to all clinical staff at band 5 and above. We will continue to monitor Duty of Candour compliance on a weekly basis with directorate governance teams and patient safety reviewers. Undertake Duty of Candour in line with statutory requirements, investigations (at local level or as defined within other learning responses) are carried out in line with national processes.
Complaints	In 2021/2022 there were 1327 complaints received. The main theme related to a lack of care/ treatment/ support. In 2022/2023 there were 959 complaints received. The main theme again related to a lack of care/ treatment/ support.	To continue to align to existing local and trust wide plans and programmes and to develop additional improvement plans in line with PSIRF. To ensure that complaints data (themes and trends) are included when this document is reviewed.
Patient experience	In 2021/2022, 7054 patients gave feedback which is above the national average. The overall patient	Improvement focused on building reciprocal partnerships with people who have relevant

Data	Summary of findings	Improvements
	experience of services was 'very good'. The positive themes related to being kind, quality of staff, and dignity and respect. The main concerns highlighted were patients feeling they were not seen enough, and not having access to ward activities and outdoors. In 2022/2023, 7836 patients gave feedback is above the national average. The overall patient experience of services was 'very good'. The positive themes related to quality of staff, caring and kind, and dignity and respect. The main concerns highlighted related to waiting times and interaction with staff.	lived experience, including with those from disadvantaged and minority communities. New areas of focus looked at the way we listen to and learn about local patient needs and understand the communities that access services and their experiences, to ask the right questions about how we and our partners work together around their needs in a way that makes sense to them and turn that understanding into action.
Care Quality Commission (CQC) – restrictive practice	KMPT was required by the CQC to ensure restrictive practices such as long-term segregation and seclusion are always in line with the MHA Code of Practice. Additionally, it was noted that care plans tend to be generic on some wards, and lacked detail, as did some behaviour support plans. There were also some concerns about courtesy when entering patient bedrooms, the environment on some wards, medication, and no displayed information for patients regarding the Mental Health Units (Use of Force Act) 2018. The CQC also noted that some patients had section 17 leave cancelled due to lack of staff availability.	At the beginning of 2022, KMPT were awarded Bild Act Accreditation for their physical interventions training following 10 months of work to meet the high expectations of the restraint reduction network training standards. The Use of Force Act work began in 2022 and involved several workstreams looking at training, patient information, serious incident investigations, reporting and recording, and policy. The work was co-produced and all resources were disseminated to all inpatient units. Through various support and clinical services overhauling our IT and patient reporting systems, we have achieved our aims at becoming compliant with national data

Data	Summary of findings	Improvements
	There was little evidence that capacity to consent to treatment for a medical disorder was assessed and reviewed in all cases.	reporting. There is still further work to be completed to improve quality of reporting. KMPT also continued to see a reduction in the number of restraints and seclusions.
Quality improvement plans and strategies	• Culture of Care programme (inpatients) • Mental Health Together (Community Mental Health Framework) • Suicide Prevention Approach • System Level Provider Collaborative Programme • Physical Health • Right Care Right Person • Violence and Aggression • Dementia • Flow/Purposeful Admission (bed strategy) • Recruitment and Retention • Care Planning Working Group • Clinical Risk Assessment and Management • Getting the Basics Right • Equality, Diversity and Inclusion strategy • Staff health and wellbeing strategy • CQC improvement plans • Directorate Quality Improvement plans	To continue to monitor existing plans and programmes and to develop additional improvement plans in line with PSIRF
Other sources		Future data will include: Freedom to speak up guardian

**For any acronyms not written out in full, please see Appendix 1: Abbreviations.*

6. Just Culture

To ensure openness and accountability, just culture is important for any organisation. The patient safety team use the Just Culture Guide (as required) in reviews and investigations. This helps to ensure an unbiased approach to investigations, and promotes the safety of staff involved in patient safety events. Staff have advised that an area the organisation can improve on is confidence in addressing unsafe practice and being safe, as well as being compassionate. Having a centralised investigation team within patient safety allows for compassionate investigation, impartial and safety of staff as the investigators have an unbiased approach.

A guidance leaflet has been developed for staff involved in incidents. This explains what the expectation of them will be and provides reassurance that investigations and reviews will be undertaken using a fair and no-blame approach.

A series of Systems Engineering Initiative in Patient Safety (SEIPS) training is being delivered for all staff within KMPT. Feedback has demonstrated that staff have gained an excellent level of understanding as a result of the training. The SEIPS model with guidance is used in all learning response templates.

We will use staff surveys and feedback to evaluate how safe staff feel when raising concerns and are involved in a patient safety event that requires a learning response.

The trust strategy (people element) aims to support staff to feel psychologically safe to report unsafe practice and events.

As a result of staff feedback, we will change the terminology that is currently used as we transition into PSIRF. For example, we will reduce use of the word ‘investigation’ when communicating with staff and replace it with ‘learning review’ and ‘learning response’. We will also reduce the use of the word ‘incident’ in favour of the term ‘event’.

The human resources team has recently appointed investigators. The investigators in this new approach now include the Just Culture Guide when completing investigations.

7. Sharing learning

This includes existing and planned mechanisms for sharing learning. Learning will be shared routinely with commissioners during the Learning Review Group meetings.

Team level	Directorate level	Trust level	External
Daily team debriefs and safety bundles	Urgent learning bulletin	Monthly learning events	Established communities of practice groups
Daily red to green board briefing	Monthly meetings to cascade learning from the directorate management teams to team level	Cascading completed investigation reports to directorate governance teams.	Urgent learning bulletin shared at national level through commissioning bodies, and regulators
Weekly MDT reviews	Quarterly learning events	Newsletter	Multi Agency Review Group
Daily clinical lead log	Bi-monthly inpatient forums	Weekly learning between directorates	Homicide Debrief (Kent and Essex Police)
	Bi-monthly quality team days	Trust Wide Patient Safety and Mortality Review Group	Community Safety Partnership

8. Our patient safety incident response plan: national requirements

The nationally defined criteria advises that the following will either be investigated by KMPT or another body:

Safety Event	Response required	Anticipated improvement route
Deaths thought more likely than not due to problems in care (unless the death falls under another category listed in this table).	Locally-led PSII by the organisation in which the event occurred If there is uncertainty whether the death was more likely than not due to problems in care, an SJR may be undertaken first to support decision making.	Create local organisational actions and feed these into/ create quality improvement strategy

Safety Event	Response required	Anticipated improvement route
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.	Locally-led PSII by the organisation in which the event occurred	Create local organisational actions and feed these into/ create quality improvement strategy
Incidents meeting the Never Events criteria 2018, or its replacement	Locally-led PSII by the organisation in which the never event occurred	Create local organisational actions and feed these into/ create quality improvement strategy
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII, with consideration of any local learning response	Respond to recommendations as required and feed actions into/ create quality improvement strategy
Maternity and neonatal incidents meeting Health Services Safety Investigation Body (HSSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSSIB or SpHA for independent PSII	Respond to recommendations as required and feed actions into/ create quality improvement strategy
Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel to agree local response type.	Respond to recommendations as required and feed actions into/ create quality improvement strategy
Deaths of persons with learning disabilities	Refer for Learning Disabilities Mortality Review (LeDeR). Liaison with the LeDeR to agree local response type.	Create/ respond to recommendations/ organisational/ system actions as required and feed actions into/ create quality improvement strategy
Safeguarding incidents in which:	Refer to local authority safeguarding lead.	Create/ respond to recommendations/ organisational/

Safety Event	Response required	Anticipated improvement route
• 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 incident relates to female genital mutilation, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	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.	system actions as required and feed actions into/ create quality improvement strategy
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response within the organisation. See: Guidance for managing incidents in NHS screening programmes.	Create/ respond to recommendations/ organisational/ system actions as required and feed actions into/ create quality improvement strategy
Deaths in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS.	Any death in prison or police custody will be referred (by the relevant organisation) to the PPO or the IOPC to carry out the relevant investigations. Healthcare organisations must fully support these investigations where required to do so.	Create/ respond to recommendations/ organisational/ system actions as required and feed actions into/ create quality improvement strategy
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.	Respond to recommendations as required and feed these into/ create quality improvement strategy

Safety Event	Response required	Anticipated improvement route
	Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHR.	

9. Our patient safety incident response plan: local focus

Safety Event	Response	Anticipated improvement route
AWOL of patients detained under the Mental Health Act resulting in harm, injury or death.	• PSII	Changes to processes through learning developed. This may be through building a case for a trust-wide improvement plan, or may be through directorate or local improvement plans, or may inform current improvement plans.
Fixed ligature incidents that occur in inpatient settings	• PSII	Changes to processes through learning developed. This may be through building a case for a trust-wide improvement plan, or may be through directorate or local improvement plans, or may inform the Suicide Prevention Approach or other current improvement plans.
Suicide of patients who have received a diagnosis of, or are awaiting an assessment for, autism and/or ADHD	• PSII	Changes to processes through learning developed. This may be through building a case for a trust-wide improvement plan, or may be through directorate or local improvement plans, or may inform the Suicide Prevention Approach or other improvement plans.

- All other events, incidents and near misses must be reported on InPhase. One of the following responses will be decided by the allocated initial investigator and the directorate governance team:
    - Local management review
    - Team level investigation and learning
    - Rapid review
        - Debrief or huddle (Rapid Review A)
        - MDT review (Rapid Review B)

- The PSIRF Incident Decision Panel will decide and confirm whether the following is required:
    - Thematic review (to be shared with commissioners)
    - AAR
    - PSII

- Safeguarding requires consideration throughout all patient safety events. Whilst there are some specific events that will follow the specialty nursing pathway for review, others may require safeguarding input or referrals. These will be reviewed by the trust safeguarding team who attend the Patient Safety Incident Decision Panel. When patients report allegations against staff, these will be managed by the HR investigation process. Where system issues are identified, a learning response may be considered.

- A Safety-II approach will help staff focus on what has led to something going right in a system or process. Identification of near miss incidents will provide good examples that can be evaluated and understood to achieve positive outcomes.

- Good and positive examples of care and treatment will be identified and shared through established learning mechanisms.

- Any events that meet the criteria for a thematic review or PSII will be managed by the patient safety team.

- For cross-system or multi-provider events, a collaborative approach to reviewing the event will be required. The patient safety team will take the lead in communicating with the other provider(s) to agree how best to take the issues forward in a joint learning response, share any learning and achieve improvement.

10. Monitoring

Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety learning reviews and PSIIs. Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.

Reports to the Quality Committee will be every 2 months, and will include aggregated data on:

- Patient safety event reporting
- Audit and review findings
- Findings from PSIIs
- Progress against the PSIRP
- Results from monitoring of improvement plans from an implementation and an efficacy point of view
- Results of surveys and/or feedback from patients/families/carers on their experiences of the trust's response to patient safety events
- Results of surveys and/or feedback from staff on their experiences of the trust's response to patient safety events
- Review of the risk register

Appendix 1: Abbreviations

AAR	After action review	**MDT**	Multidisciplinary team
ADHD	Attention deficit and hyperactivity disorder	**MHA**	Mental Health Act
AMHP	Approved Mental Health Practitioner	**NHSE**	NHS England
AWOL	Absent without leave	**PALS**	Patient advice and liaison service
CQC	Care Quality Commission	**PFD**	Prevention of Future Deaths (notification)
CSP	Community Safety Partnership	**PPO**	Prison and Probation Ombudsman
DHR	Domestic Homicide Review	**PSII**	Patient safety incident investigation
DVT	Deep vein thrombosis	**PSIRF**	Patient safety incident response framework
ECG	Electrocardiogram	**PSIRP**	Patient safety incident response plan
HR	Human resources	**RCA**	Root cause analysis
HSSIB	Health Services Safety Investigation Body	**RIIT**	Regional Independent Investigation Team (NHS England)
IOPC	Independent Office for Police Conduct	**SEIPS**	Systems engineering initiative in patient safety
KMPT	Kent and Medway NHS and Social Care Partnership Trust	**SJR**	Structured judgment review
LeDeR	Learning Disabilities Mortality Review	**SpHA**	Special Healthcare Authority

Appendix 2: Never Events

The table below displays the Never Events relevant to our trust, as set out by NHS England in their currently published list.

Never Event	Description
Mis-selection of a strong potassium solution	When a patient is intravenously given a strong (≥10% potassium w/v (eg ≥0.1 g/mL potassium chloride, 1.3 mmol/mL potassium chloride) potassium solution rather than the intended medication.
Administration of medication by the wrong route	• intravenous chemotherapy by the intrathecal route • oral/enteral medication or feed/flush by any parenteral route • intravenous administration of an epidural medication that was not intended to be administered by the intravenous route
Overdose of insulin due to abbreviations or incorrect device	• a patient is given a 10-fold or greater overdose of insulin because the words 'unit' or 'international units' are abbreviated; such an overdose was given in a care setting with an electronic prescribing system • a healthcare professional fails to use a specific insulin administration device – that is, an insulin syringe or pen is not used to measure the insulin • a healthcare professional withdraws insulin from an insulin pen or pen refill and then administers this using a syringe and needle.
Overdose of methotrexate for non-cancer treatment	When a patient is given a dose of methotrexate, by any route, for non-cancer treatment that is more than the intended weekly dose; such an overdose was given in a care setting with an electronic prescribing system.
Mis-selection of high strength midazolam during conscious sedation	• a patient is given an overdose of midazolam due to the selection of a high strength preparation (5 mg/mL or 2 mg/mL) instead of the 1 mg/mL preparation, in a clinical area performing conscious sedation • excludes clinical areas where the use of high strength midazolam is appropriate; these are generally only those performing general anaesthesia, intensive care, palliative care, or areas where its use has been formally risk-assessed in the organisation.
Failure to install functional collapsible shower or curtain rails	• failure of collapsible curtain or shower rails to collapse when an inpatient attempts or completes a suicide

	• failure to install collapsible rails and an inpatient attempts or completes a suicide using non-collapsible rails.
Falls from poorly restricted windows	• windows 'within reach' of patients; this means windows (including the window sills) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to climb out of the window • windows located in facilities/areas where healthcare is provided and that patients can and do access • where patients deliberately or accidentally fall from a window where a fitted restrictor is damaged or disabled, but not where a patient deliberately disables a restrictor or breaks the window immediately before they fall • where patients can deliberately overcome a window restrictor using their hands or commonly available flat-bladed instruments as well as the 'key' provided.
Chest or neck entrapment in bed rails	Entrapment of a patient's chest or neck between bedrails or in the bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance.
Misplaced naso- or oro-gastric tubes	Misplacement of a naso- or oro-gastric tube in the pleura or respiratory tract that is not detected before starting a feed, flush or medication administration.
Scalding of patients	Patient scalded by water used for washing/bathing. Excludes scalds from water being used for purposes other than washing/bathing (eg from kettles).
Unintentional connection of a patient requiring oxygen to an air flowmeter	This applies when a patient who requires oxygen is connected to an air flowmeter when the intention was to connect them to an oxygen flowmeter. Excludes unintentional connection to an air cylinder instead of an oxygen cylinder as robust barriers to prevent this have not yet been identified.