Patient safety incident response plan

Effective date: 1st April 2024

Estimated refresh date: 1st April 2025

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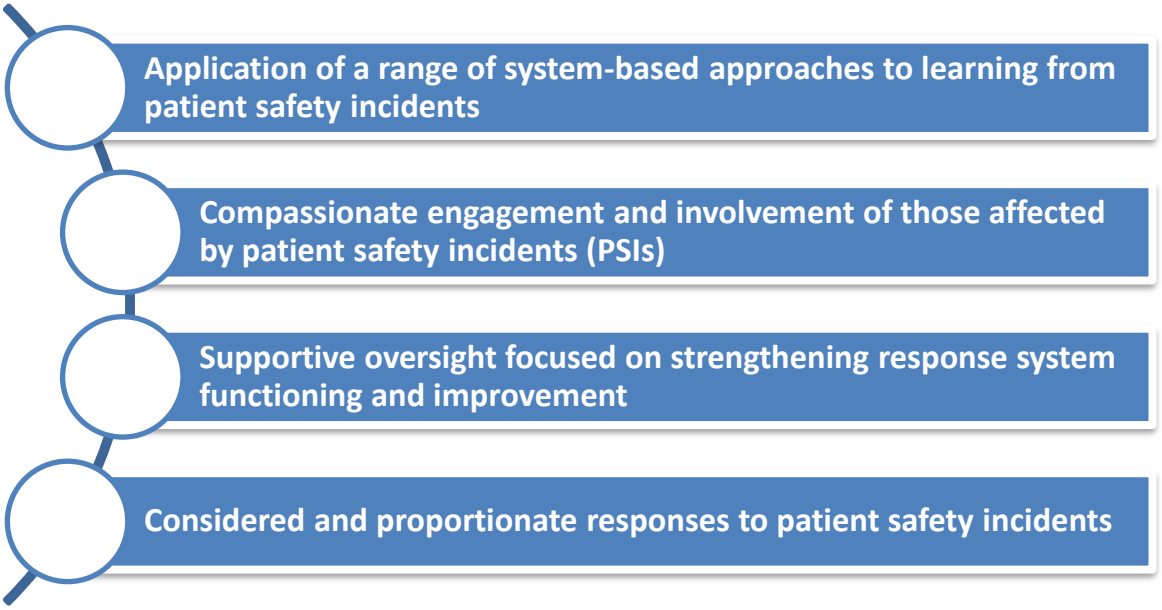
Introduction

This Patient Safety Incident Response Plan (PSIRP) outlines The Children's Trust's approach to managing patient safety incidents reported by the children and young people we serve, their families, carers, and our staff. The plan sets out our process for responding to patient safety incidents (PSI) and our improvement and safety goals for the next 12-to-18-month period. It is a key component of our ongoing commitment to the highest standards of care and the safety in our organisation.

Flexible and data-driven, this plan is tailored to address the unique circumstances of each incident and the needs of those impacted. Focused on system learning, risk reduction, and preventing recurrence, it aligns with our broader policies on incident management and patient safety.

The Children's Trust PSIRP outlines our commitment to learning from incidents to enhance care quality and safety, part of our ongoing improvement efforts. It details establishing an effective patient safety response system, aligning with the PSIRF's four core aims.



Responses covered in this Plan include:

• Patient Safety Incident Investigations (PSIIs)

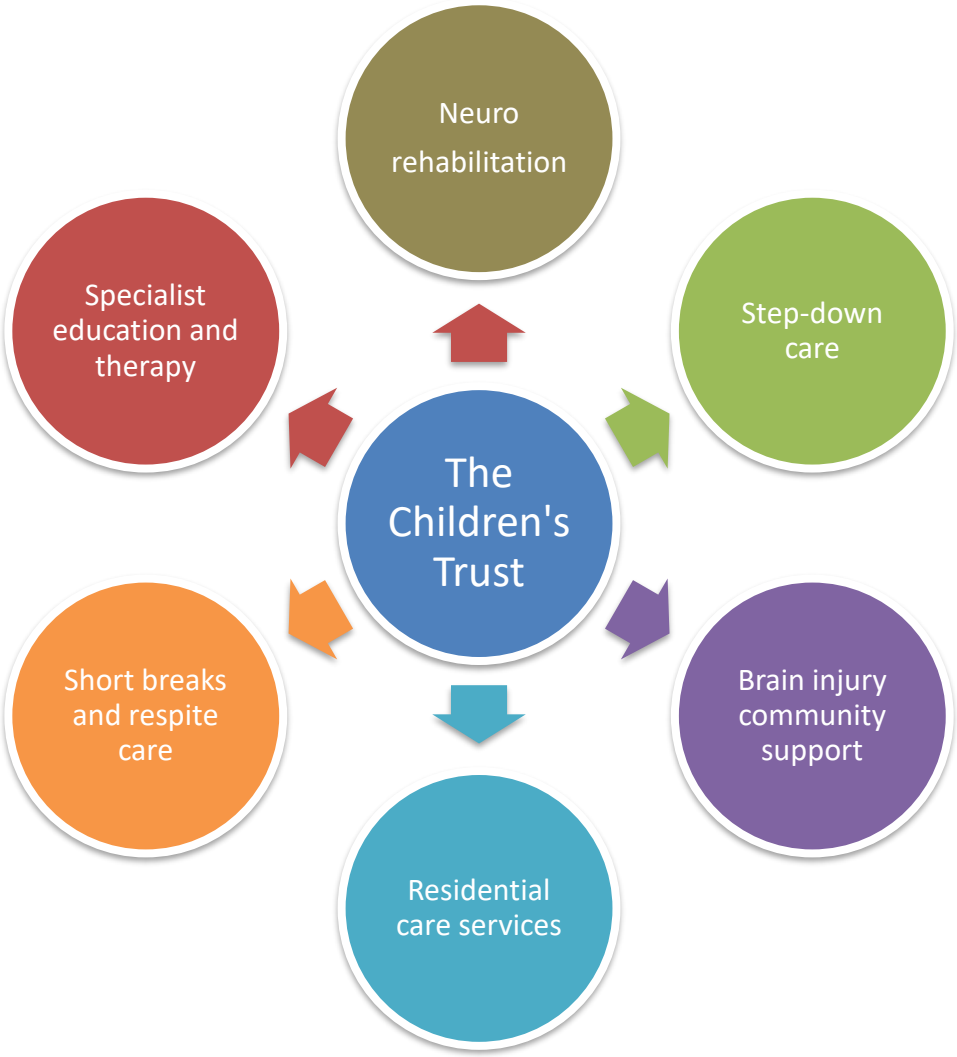
• Patient Safety Reviews (PSRs)

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

Our services

The Children's Trust is the UK's leading charity for children with brain injury. We work with children and young people aged 0-19 years old from across the UK with acquired brain injury (ABI), neurodisability, and complex education, therapy, health, and care needs.

Key services include:



Nestled in the beautiful grounds of Tadworth Court Manor, The Children's Trust offers a specialist skills and services for children with brain injuries and complex health needs. With seven residential houses, the Children's Trust School and facilities including a therapy centre and hydrotherapy pool, we offer around 60 inpatient/residential beds, plus facilities for day attenders at our school and therapy centres, we stand as a comprehensive care provider. Our dedicated team of over 300 clinical staff, including carers, nurses, therapists, psychologists, and a dedicated medical team, ensures personalised and holistic care. Accepting referrals nationwide, we're not just limited to our physical premises; our extensive community rehabilitation service, outpatient work and digital resources extend our expertise in brain injury support across the UK, reinforcing our commitment to enhancing the lives of children and their families.

Neurorehabilitation

The residential neurorehabilitation we provide at our national specialist centre in Tadworth, Surrey, is the largest service of its kind in the UK. We help children restore lost skills or develop new ways of doing things, all the time supporting the family with their child's newly acquired disability, transition home and plan for the future.

Long term respiratory care and step-down services

TCT specialises in transitional and step-down care, focusing on long-term respiratory support, including ventilator and tracheostomy care. The service extends to neurorehabilitation, step-down care, providing respite services and short breaks. This comprehensive approach ensures a continuum of care for children requiring extensive medical and rehabilitative support.

The Children's Trust School

Our school caters to children and young people aged 2 to 19 with special needs, including neurodisability, offering a nurturing environment for both residential and day pupils. Our comprehensive early years program features Tadworth Tots Nursery and Taddies for informal sessions. We focus on creating a supportive atmosphere that fosters every child's intellectual, physical, emotional, and social growth, working closely with parents to enhance each child's quality of life.

Community Rehabilitation Service (CRS)

We provide specialist goal-orientated neurorehabilitation delivered in the child's environment and on an outpatient basis, offering online information and resources, as well as support to children, young people, and families through a nationwide virtual acquired brain injury team. In addition, the team offers an intensive, hands-on therapy service to children and young people living in the southeast, alongside virtual hybrid packages of support for those further afield. Our ultimate goal is to maximise the child's participation in everyday life.

Brain Injury Hub

Our Information Service, which consists of the Brain Injury Hub and our publications, reaches families mainly in the UK, but also across the globe, providing families with free support and advice.

Aims and Objectives

Over the year to come we will be rolling out the PSIRF framework, focusing on its four main pillars to boost patient safety at The Children's Trust. Below, you'll find our key goals for each pillar, showing our plan to make care safer and learning continuous for everyone involved.

PSIRF Aims	Patient Safety and Quality Improvement Specific Objectives
Compassionate engagement and involvement of those affected by patient safety incidents	• Cultivate an environment that champions a just culture, supporting fairness and understanding. • Enhance our communication and support for everyone involved in patient safety incidents, ensuring clarity and compassion. • Actively involve and support patients, families, carers, and staff in our incident response processes. This collaborative approach aids in a deeper understanding of incidents, contributing factors, and fosters shared learning.
Application of a range of system-based approaches to learning from patient safety incidents	• Integrating systems thinking into our investigative processes, ensuring a holistic understanding of incidents. • Ensuring a uniform approach to investigations across all levels, promoting consistency and reliability. • Incorporating systems thinking into our learning from incidents and quality improvement efforts, facilitating comprehensive improvements based on a deep understanding of systemic interactions
Considered and proportionate responses to patient safety incidents	• Reduce the number of duplicate PSIIs into the same type of incident, enable more resource to be focused on effective learning and enable more rigorous investigations that identify required system improvements. • Responding proportionately will allow us to focus more resources in areas with the highest potential for learning and improvement. This will drive our decision making rather than the severity of incident outcomes.
Supportive oversight focused on strengthening response system functioning and improvement	• Create comprehensive system improvement plans by analysing aggregated data from incident responses, aiming for systemic enhancements. • Enhance the evaluation of our improvement initiatives, ensuring they are effectively informed by the insights gained from incident responses. • Forge closer working relationships with our ICB and other local providers to share learning and insight

We will align PSIRF with our risk management approach and other relevant management practices (e.g. budgeting, business planning and strategy development.

Defining our patient safety incident profile

Starting our PSIRF journey later meant navigating tighter timelines for comprehensive data analysis and stakeholder engagement. However, by reviewing our incident data and collaborating with key clinical teams and partners, we've laid a foundation for our PSIRF plan and identified our areas of focus. This process will continue to evolve as we implement the framework. As a living document, our PSIRF plan may see adjustments to targets based on ongoing analysis and feedback, ensuring our approach remains dynamic and responsive to the needs of those we serve.

Scope

Our plan covers all patient safety activity at our main site in Tadworth and does not include non-clinical areas such as fundraising and The Children's Trust charity shops. It does extend to our community services, all of which operate from within our Tadworth location.

Stakeholder engagement to date

Stakeholder	Involvement
All staff	• Through incident reporting using the TCT incident system (IRAR) • An online survey seeking feedback on our current practice, Views on our key areas of focus and what they would like to see change as the framework is implemented
Nursing and care staff	• A PSIRF discussion slot has taken place on all recent team days. This allowed us to further explain the framework and discuss the potential changes and understand the views of our clinical workforce
Senior nursing leadership / core project team	• The team collected the incident data and conducted the initial analysis. The team used the data collected to propose the targets outlined in this document
Senior leadership	• The clinical leaders have attended the face-to-face PSIRF training. • The framework has been discussed at our senior leadership meetings for oversight
Board of Trustees	• The board of trustees have been involved in oversight of our policy, plan, and procedures

Planned future stakeholder engagement.

Over the coming 12 months we intend to

- initiate a regular patient safety forum that is open to all staff to attend and contribute to.
- Increase our engagement with the children/young people and families and initiate a regular patient safety partners forum (within 3 months).
- Continue to have a regular slot of all team days to discuss implementation and challenges. (Across the next 12 months)
- Run a senior leadership and trustees PSIRF implementation workshop. (Within 2 months)
- Perform periodic online evaluations for staff to evidence the impact of the changes on the clinical teams and continue to collect ideas and input from them as we implement the framework. (Every 3 months)

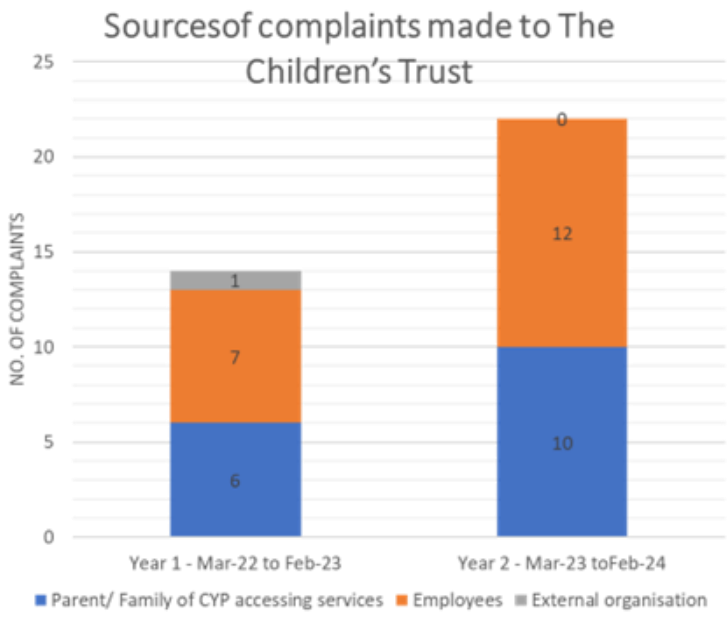
Defining our patient safety improvement profile

Our data collection encompassed various sources, capturing a comprehensive snapshot of incidents and complaints within The Children's Trust. Through meticulous analysis of this data, including hundreds of incidents reported over the past year, we've gained valuable insights into the patterns and primary causative factors affecting patient safety. This information has been instrumental in identifying key areas for improvement and setting focused priorities as we embark on our PSIRF journey.

Data sources

- **Incident reports:** A data review of the 'Incidents & Risk Assessment Reporting System' (IRAR) was conducted for incidents reported between March 2022 and February 2024. The frequency and level of investigation was assessed for each incident category.
- **Complaints:** Complaints made between March 2022 and February 2024 were reviewed and a thematic analysis undertaken which was linked to corresponding incident categories.

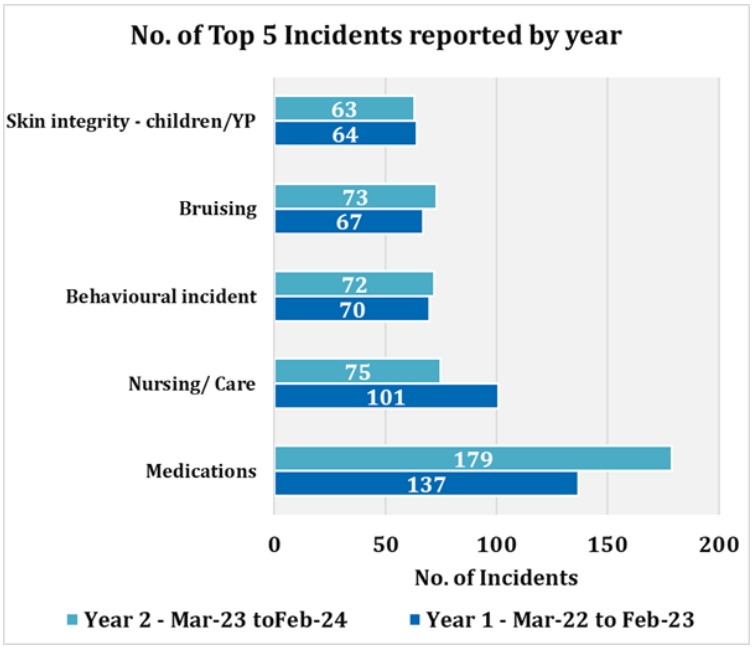
Complaints

Themes from complaint sources	
Parent/ Family ▪ Relating to the care of their child = 12 (75%) ▪ Relating to the therapy that their child receives = 3 (19%) ▪ Relating to the overall placement = 1 (6%)	
Employees ▪ Relating to another employee = 7 (37%) ▪ The provision of care = 4 (21%) ▪ Parental behaviour = 4 (21%) ▪ Staffing levels = 3 (16%) ▪ Catering provided = 1 (5%)	
External organisation ▪ Infection prevention & Control = 1 (100%)	

All (**100%**) complaints made over the 2-year period were 'Negligible' severity grade and 'Low' risk.

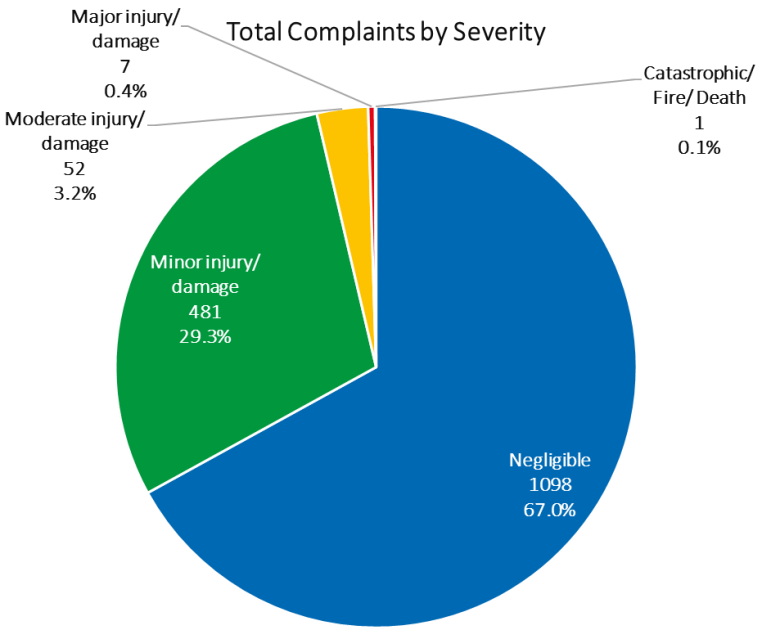
The outcomes and interventions following complaints from the families of children/young people accessing services have led to improved methods of communication between teams and parents, such as a review of parental information and rehabilitation timetables. Where the families of service users have raised complaints or concerns regarding the care of their child, then historically full investigations and root cause analysis have been carried out.

Incidents

Narrative	Top 5 incidents
Between March 2022 and February 2024, a total of **1,639** incidents have been reported and logged on IRAR: ▪ **2022/23 = 810** ▪ **2023/24 = 829** During this period 55% of the incidents raised fall into the 5 categories shown Overall, there were over 40 different categories of incident and the other key areas we have been monitoring and implementing improvements in are. Manual handling = 115 incidents Equipment = 93 incidents Slips, trips, and falls = 70 incidents	

Between March 2022 and February 2024, a total of 3.7% incidents were classed as moderate injury/damage and above.

- Moderate injury/damage = 3.2%
- Major injury = 0.4%
- Catastrophic/fire/death = 0.1%



We have conducted 2 serious investigations over the last 24 months year related to unexpected deaths. These have both included commissioning an external investigator. Both investigations are awaiting a coroner review.

Medication incidents

While medication incidents have aligned with national averages in past years, a notable increase has occurred in the last six months, particularly with omissions, alongside issues in prescription, administration, and handling. In response, we've intensified our medication administration training. This area will remain a key focus to ensure the utmost safety in medication administration for our children and young people.

Bruising incidents

Our culture promotes vigilant reporting of all bruising, crucial for safeguarding the highly vulnerable children and young people we support. Given their susceptibility to bruising, particularly due to manual handling and orthotic equipment, prioritizing monitoring practices in these areas is essential. Our focus for 2024 is on minimizing bruising occurrences while maintaining a good recording culture. A thematic review will be undertaken to identify patterns and emergent themes that may lead to learning and influence future practice.

Another key area in within this is fractures. The children/young people we care for have an increased risk of fractures due to low bone density and mobility issues. Fractures are rare but would need a full investigation to find out the cause and what we can learn for future practice.

Nursing and Care

Incidents related to nursing and care encompass a wide range, including supervision levels, adherence to care plans and protocols, documentation accuracy, and errors in areas such as vital sign monitoring/PEWs, nutrition, and personal care delivery. For 2024, our focus will be on enhancing documentation, optimizing care planning and electronic records, and ensuring protocols and care plans are easy to understand and follow, to improve overall care quality and safety. We also have a focus on supervision levels and ensuring staff understand the levels observation our children/young people require and why.

Behavioural incidents

Behavioural incidents in children and young people at TCT often stem from challenges related to brain injury and neurodisability, manifesting as difficulties with stimulation and emotional regulation. Such behaviours necessitate compassionate, specialized management plans tailored to individual needs. Our focus is on continuously refining these plans and our approaches to supportively address and guide these behaviours, ensuring each child's well-being and development within a nurturing environment. This involves a dedicated effort to understand and mitigate the underlying causes, promoting a positive and safe setting for all.

Skin integrity

Given the vulnerability of children and young people with disabilities to skin integrity issues, focusing on pressure areas, skin marking, stoma site concerns, and post-surgery wound care is crucial. The appointment last year of a tissue viability lead, spearheading initiatives in this domain, marks an important step forward. This focus is set to enhance outcomes, emphasizing preventative measures and specialized care plans tailored to each individual's needs.

We already have several improvement projects attempting to address some of the issues highlighted above including.

- Handover project – Our senior nurses are in the process of implementing a new site wide handover system that they designed themselves as part of a programme of study.
- Parent medication competency and administration record project
- Thematic review of respiratory protocols and escalation incidents
- Thematic review of recent medication incidents
- PEWs update and the deteriorating child policy project.
- Safer sleeping including bedrails project.

Our patient safety incident response plan: national requirements

Local patient safety risks and/or events that fall within the national priority and reporting scope.

There are other events that have a recommended response (mental health related homicide, maternity and neonatal incidents, deaths in NHS screening programmes, death in custody and domestic custody). These have not been separately stated in this PSIRP as they are unlikely to occur due to the nature of care offered by The Children's Trust. Should such an event occur, the recommended action set out by NHS England will be followed.

Patient safety incident type	Type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	All	Locally led PSII	Create local organisational actions and feed these into the quality improvement strategy.
Child/Young person death	Death of a child that is unexpected	Liaise with CDOP Locally led PSII. and/or External PSII	Liaise with CDOP and respond to recommendations from external parties. Create organisational actions and feed these into quality Improvement strategy
	Death of a child that is expected or palliative in nature	Liaise with CDOP MDT review and/or Locally led PSII.	Liaise with CDOP and Respond to recommendations from external parties. Create organisational actions and feed these into quality Improvement strategy
Safeguarding incidents	Possibly due to staff actions/inaction	Liaise with Local Authority Designated Officer (LADO) to agree response type and timelines. TCT internal investigation and/or PSII	Liaise with LADO to agree outcomes. Create local organisational actions and feed these into the quality improvement strategy

	Not due to staff actions/inactions	Refer to local authority safeguarding lead to agree if internal investigation appropriate.	Contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice 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. Respond to recommendations from external parties
Deaths of persons with learning disabilities	Young people aged over 18	Locally Led PSII (or other response) may be required alongside the LeDeR	Refer for Learning Disability Mortality Review (LeDeR) Respond to recommendations from external parties.

Our patient safety incident response plan: local focus

The Children's Trust, in collaboration with key stakeholders, has established local patient safety priorities for 2024/2025. This process involved a comprehensive analysis of our patient safety profile, incorporating insights and feedback to define these priorities.

A chief aim of PSIRF is to undertake higher quality patient Safety Incident Investigations (PSII) employing system review methodology to maximise effective and sustained learning and improvement. This will may mean fewer but more significant investigations for the national and local priorities detailed in this plan.

When deciding whether to investigate and which methodologies to employ we will consider the following factors.

Our decision-making flowchart can be found at the end of the document (Appendix 2)

Criteria	Considerations
Potential for learning	• People: physical, psychological, loss of trust (patients, family, caregivers) • Service delivery: impact on quality and delivery of healthcare services; impact on capacity. • Public confidence: including political attention and media coverage. • Potential to inform improvement. • Learning responses from good or positive care
Likelihood of occurrence	• Persistence of the risk • Frequency • Potential to escalate

Patient safety incident type or issue	Planned response options	Anticipated improvement route
Any incidents resulting in moderate or severe physical or psychological harm (as per LFPSE definitions)	Either and/or • Statutory duty of candour • Swarm huddle • After action review • PSII	Patient Safety Oversight Group (PSOG) to review a decide level of response. Liaise with LADO Create local safety actions and feed these into the quality improvement strategy.
Any medication incidents with the potential for new learning.	Either and/or • Statutory duty of candour • Swarm huddle • PSII if indicated.	Patient Safety Oversight Group (PSOG) to review a decide level of response. Liaise with LADO.

Any significant increases in medication incidents or emerging themes	• TCT internal investigation (safeguarding) • Thematic review	Feed into the medication incident group. Create local safety actions and feed these into t quality improvement strategy.
Any pressure areas or wound/tissue breakdown above a grade 2	Either and/or • MDT review • Swarm huddle • PSII if indicated	Patient Safety Oversight Group (PSOG) to review a decide level of response. Liaise with LADO if appropriate Create local safety actions and feed these into the tissue viability group and quality improvement strategy.
Any fracture incidents	Either and/or • Statutory duty of candour • After action review • MDT review • TCT internal investigation (safeguarding) • PSII	Patient Safety Oversight Group (PSOG) to review a decide level of response. Liaise with LADO Create local safety actions and feed these into the quality improvement strategy.
Bruising incidents where there is potential for new learning. Any significant increases in bruising incidents or emerging/concerning patterns	Either and/or • MDT review • TCT internal investigation (safeguarding) • Thematic review	Patient Safety Oversight Group (PSOG) to review a decide level of response. Liaise with LADO Create local safety actions and feed these into the quality improvement strategy...
Behavioural incidents resulting in harm to a child/young person or staff member or where there is potential for new learning	Either and/or • Swarm huddle • After action review • MDT review • PSII if indicated	Patient Safety Oversight Group (PSOG) to review a decide level of response. Liaise with LADO if appropriate. Create local safety actions and feed these into the quality improvement strategy...
Incidents where there has been significant harm or the potential for significant harm related to deteriorating patients specifically: • Problems in identifying deterioration. • Problems in escalating care	Either and/or • Swarm huddle • After action review • Thematic review • PSII if indicated	Patient Safety Oversight Group (PSOG) to review a decide level of response. Liaise with LADO if appropriate. Create local safety actions and feed these into the quality improvement strategy

Any incidents where a child requiring continuous care, or continuous observations have been left unattended	Either and/or • After action review • MDT review • TCT internal investigation (safeguarding) • PSII if indicated	Patient Safety Oversight Group (PSOG) to review a decide level of response. Liaise with LADO Create local safety actions and feed these into the quality improvement strategy
Infection prevention Control incidents (IPC)	Either and/or • Swarm huddle • After action review • MDT review • Thematic review • PSII if indicated	Patient Safety Oversight Group (PSOG) to review a decide level of response in partnership with ICP lead. Create local safety actions and feed these into the IPC meeting and quality improvement strategy

Infection Prevention and Control Reviews

In line with NHS England guidance and our existing Infection Prevention and Control (IPC) procedures and policies The Children's Trust will carry out IPC Reviews under PSIRF where they meet the considerations for wider learning, impact on patient well-being and likelihood of occurrence. This does not change the current methods of mandatory reporting through HCAI Data Capture System of key alert infections such as MRSA, E. coli, MSSA bacteraemia's and C. difficile.

Assurance and monitoring of effectiveness

At The Children's Trust, improvement plans, and their effectiveness are overseen by the quality committee, with incident assessments and responses monitored by governance processes and the patient safety oversight group (PSOG). This is led by the head of PSIRF and Quality alongside the clinical directors.

This team also coordinates learning, feedback, and safety culture improvements, incorporating staff feedback and survey results. Patient Safety Investigations' findings are integrated into the organisation's quality and improvement tracker, with regular reviews ensuring actions are aligned with safety objectives. Feedback is provided to teams for ongoing enhancement of patient safety practices.

Periodic reviews of our incident response process and the effectiveness of our improvement actions are integral to The Children's Trust. These evaluations ensure we foster a safety culture, demonstrate continuous learning, and are effectively implementing the new framework.

Regular update reports will be created for clinical governance and safeguarding committee and board assurance.

Conclusion

The Children's Trust's PSIRP, in line with NHS England's PSIRF, outlines our commitment to improving care quality and safety through a systematic response to patient safety incidents. This new approach encourages a cultural evolution towards more effective safety management, leveraging coordinated efforts and data insights. While embracing this shift, we anticipate initial challenges, yet remain dedicated to continuous evaluation and adaptation of our practices, supported by our community and safety partners. PSIRF represents a significant opportunity for learning, improvement, and the enhancement of care for our children, families, carers, and staff.

Appendix 1 - Glossary of terms

TCT (The Children's Trust): Our organisation abbreviated**.**

PSIRF (Patient Safety Incident Review Framework): Defines NHS guidelines for establishing robust systems and processes to address patient safety incidents, focusing on learning, and enhancing patient safety.

PSIRP (Patient Safety Incident Response Plan): A mandate for all entities offering NHS-funded services, applicable to patient safety incidents within both NHS and private healthcare settings.

PSI (Patient Safety Incident): Any unforeseen event that has the potential to, or does, harm one or more patients in healthcare.

PSII (Patient Safety Incident Investigation): Inquiries conducted to unearth contributing factors to an incident, synthesizing findings to pinpoint recurring themes and learning opportunities, culminating in comprehensive improvement strategies.

PSR (Patient Safety Review): An examination of patient safety incidents to pinpoint issues, implement immediate corrective actions, identify enhancement areas, and address concerns from patients, families, or carers, aiming for service improvement.

PSOG (Patient Safety Oversight Group): Led by the head of PSIRF/Quality, this group are responsible for the oversight of all patient safety activities.

Swarm Huddle: An immediate, post-incident safety discussion led by a designated coordinator, involving all relevant participants, fostering open, blame-free dialogue to analyse the incident and assess PSII applicability.

AAR (After Action Review)/Cold Debrief: A reflective discussion, conducted anytime post-incident, allowing participants to evaluate what happened, successes, areas for improvement, and lessons learned.

Thematic Reviews: Comprehensive analyses focusing on patterns or themes across multiple incidents to identify systemic issues and opportunities for widespread organizational learning and improvement.

SEIPS (Systems Engineering Initiative for Patient Safety): A framework for analysing healthcare systems and processes to enhance patient safety by focusing on the interactions among system components.

HFIX (Human Factors Integration): An approach that incorporates human factors principles into healthcare practices and system designs to improve safety, performance, and satisfaction.

Never Event: Incidents that are wholly preventable, with national guidelines and safety recommendations in place to establish strong systemic safeguards.

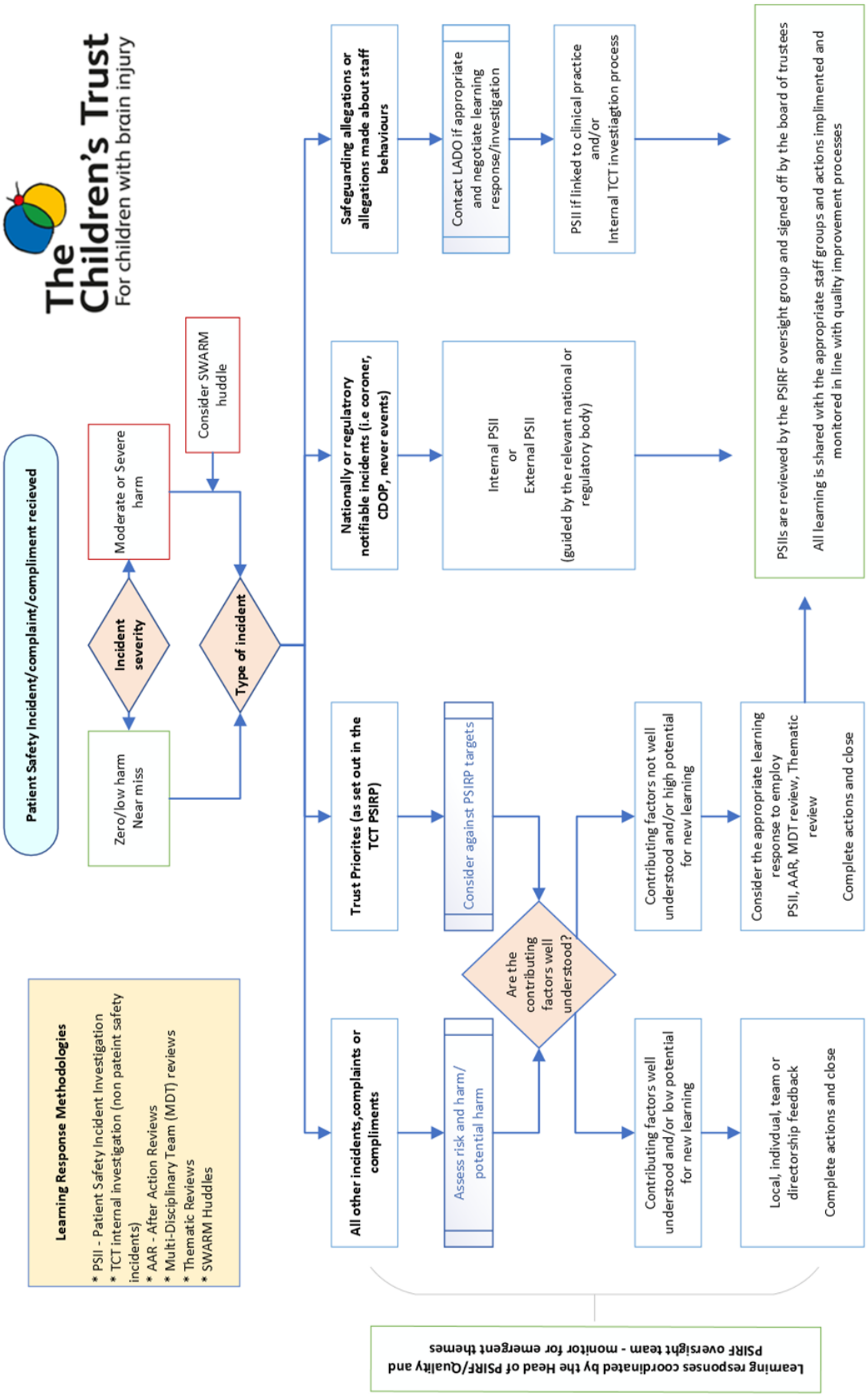
Duty of Candour: The professional and legal obligation of healthcare providers to maintain openness and honesty with patients when adverse events occur.

LADO (Local Authority Designated Officer): The LADO is responsible for managing and overseeing investigations into allegations or incidents where a child may have been harmed or put at risk due to the actions or inactions of a staff member. Their role is pivotal in determining the necessity and scope of an investigation to ensure child safety and welfare.

ICB (Integrated Care Board): A statutory NHS body responsible for planning healthcare services, managing budgets, and ensuring service provision within a specific region.

SMART Goals: A criteria set for objective setting, ensuring goals are Specific, Measurable, Achievable, Relevant, and Time-bound, facilitating clear, actionable targets.

Appendix 2


The Children's Trust
For children with brain injury
Patient Safety Incident/complaint/compliment recieved
Incident severity
Zero/low harm
Near miss
Moderate or Severe harm
Consider SWARM huddle
Type of incident
All other inidents,complaints or compliments
Assess risk and harm/ potential harm
Are the contributing factors well understood?
Contributing factors well understood and/or low potential for new learning
Local, individual, team or directorship feedback
Complete actions and close
Trust Priorites (as set out in the TCT PSIRP)
Consider against PSIRP targets
Contributing factors not well understood and/or high potential for new learning
Consider the appropriate learning response to employ PSII, AAR, MDT review, Thematic review
Complete actions and close
Nationally or regulatrory notifiable incidents (i.e coroner, CDOP, never events)
Internal PSII
or
External PSII
(guided by the relevant national or regulatory body)
Safeguarding allegations or allegations made about staff behaviours
Contact LADO if appropriate and negotiate learning response/investigation
PSII if linked to clinical practice and/or
Internal TCT investiagtion process
PSIIs are reviewed by the PSIRF oversight group and signed off by the board of trustees
All learning is shared with the appropriate staff groups and actions implimented and monitored in line with quality improvement processes
Learning Response Methodologies
* PSII - Patient Safety Incident Investigation
* TCT internal investigation (non pateint safety incidents)
* AAR - After Action Reviews
* Multi-Disciplinary Team (MDT) reviews
* Thematic Reviews
* SWARM Huddles
Learning responses coordinated by the Head of PSIRF/Quality and PSIRF oversight team - monitor for emergent themes