Patient Safety Incident Response Plan

DECEMBER 27

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Patient Safety Incident Response Framework

Executive summary

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. In line with the NHS Patient Safety Strategy (2019), patient safety is about maximising the things that go right and minimising the things that go wrong. While patient safety incidents are rare, SCUK priorities compassionate engagement with patients, family and staff affected by incidents. This provides vital insight into how to improve care, ultimately making services safer for patients. The focus is on understanding how incidents happen – including the factors which contribute to them.

This Patient Safety Incident Response Strategy delineates the comprehensive framework through which Secure Care UK (SCUK) commits to address patient safety incidents. This plan takes account of the context in which each incident occurs and focuses on identifying learning to prevent patient safety incidents from learning in the future.

SCUK has embraced the tenets of the Patient Safety Incident Response Framework. This framework is built upon principles of transparency, equitable accountability, knowledge acquisition, and continuous refinement. SCUK's commitment extends to fostering compassionate engagement with impacted patients, families, and staff.

This document should be read alongside our Incidents, reporting and accidents policy.

About Us

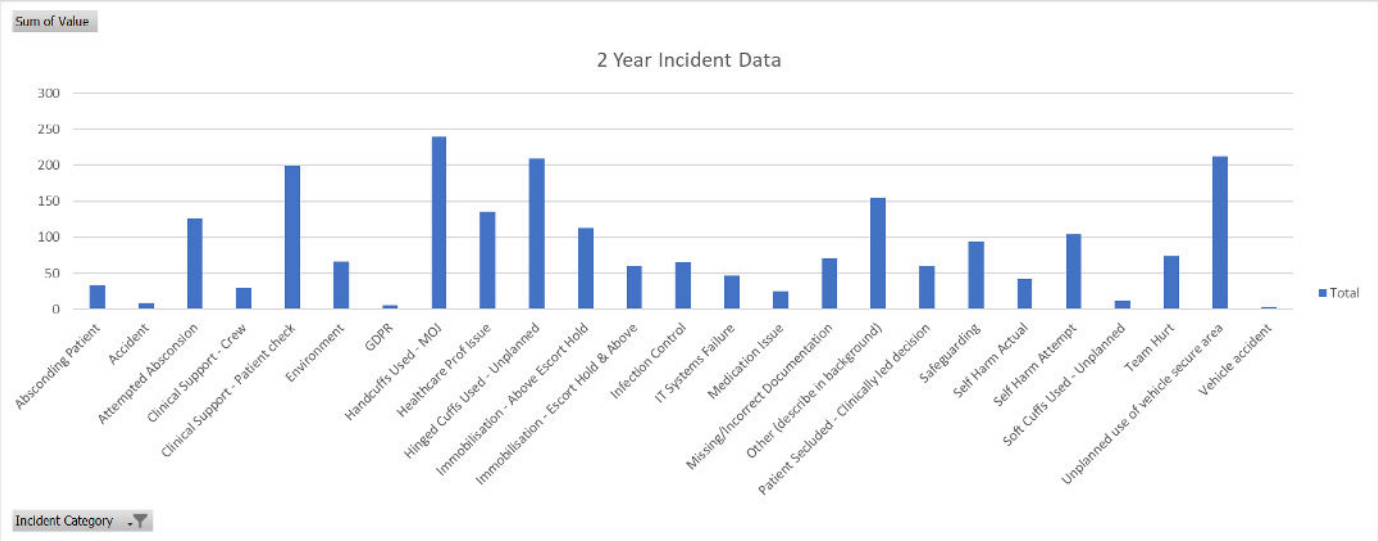
SCUK's specialised domain centres on Mental Health Patient Transport and Care. Importantly, it is paramount to acknowledge that SCUK does not administer clinical or medical interventions beyond emergency first aid. In health-based settings, clinical leadership governs patient care, underscoring the company's role within the broader healthcare ecosystem.

With operational bases spanning 10 locations (two of which house control centres) and two additional regions, SCUK's geographical footprint extends across the entirety of the United Kingdom. Collaborating with diverse stakeholders including NHS Trusts, Integrated Care Boards (ICBs), and Police services, SCUK's reach, and influence are in a dynamic state of expansion.

Strategic Prioritization: A Data-Driven Approach

The formulation of this plan rests upon an analysis of 2,191 incidents logged via the Patient Care Record system (SCIPS) over the past 24 months. This analysis encompassed various incident categories including complaints, non-conformance, near-misses, and risk register entries. The most pronounced risk to patient safety in SCUK's care environment stems from patients' self-harming or risk behaviours. It is noteworthy that SCUK's staff employ techniques approved by the restraint reduction network, underpinned by BILD-accredited training.

In this time frame there were a total of 2657 uses of physical intervention methods recorded. The criteria for reporting these as an incident was set at 'Immobilisation Above and Escort Hold' at the time that these were recorded, as such 433 occasions may have resulted in an incident report being required, we do however also need to recognise the multiple methods may have been used in the same period of restraint and as such this number is expected to be considerably lower. The current criteria requires reporting of 'Immobilisation Escort Hold and above', if this criteria was added to the data there would be a further 249 incidents, but as above, these would also be seen as part of multiple restraint methods in the same incident. The remaining 1791 records of intervention consist of support holds such as guiding and prompting methods.



Staff Engagement and Organisational Culture

Supplementing SCUK's incident response plan, an in-depth staff survey was undertaken to gauge the culture around incident reporting, accessibility of reporting mechanisms, and sharing of learning from incidents across the organisation. Employing Microsoft Forms, this survey garnered insights from a range of staff across the organisation, culminating in a 35% response rate.

Survey outcomes underscore the following key insights:

- **Awareness:** 95% of respondents were cognizant of the incident reporting system**.**
- **Confidence:** 85% expressed confidence in their ability to report incidents.
- **Simplicity:** 78% perceived the incident reporting process as straightforward.
- **Comprehensiveness:** 91% reported all incidents they encountered**.**
- **Review Efficacy:** 63% believed incidents received adequate reviews; shortcomings stemmed from lack of feedback or actionable outcomes.
- **Blame Culture:** 49% believed a blame-free culture existed, signifying room for further fostering a just culture. 32% were neutral and 18% were not confident that a blame free culture existed. Although this was only 18% of a 35% response rate for the organisation, it should be assumed that this might be higher and as such, requires addressing through our promotion and embedding of Just Culture.
- **Learning Dissemination:** 56% acknowledged that there was sharing of internal learnings, however, a drive to ensure we are capturing all staff when there are

organisational learnings is required. We are currently exploring how we communicate and how staff would prefer to be engaged with.

The survey highlighted a need to improve communication regarding incidents. Technological and environmental challenges were spotlighted, in line with SCUK's operations. Examples of this are; a new communication platform, Harri, to replace the old social media type platform currently in place. Implementation of Asana, a project and task management platform, allowing greater oversight for tracking actions following investigations and, in line with our ISO 9001:2015 accreditation, a more structured learning and improvement register.

As a result of this survey, we have produced a Quality Pledge, engaging with other departments to try and improve the communication process and close the feedback loop.

National Standards – The Mental Health Safety Improvement Programme

The NHS England Mental Health Safety Improvement Programme aims to improve the safety and outcomes of mental health care by reducing unwarranted variation and providing a high-quality healthcare experience for all people across the system by March 2024. Although the main focus is in inpatient settings, these standards have been implemented and absorbed into our patient safety priorities.

- **Reduce suicide and self-harm in inpatient mental health services, the healthcare workforce and non-mental health acute settings.**
- **Reducing the incidence of restrictive practice in inpatient mental health and learning disability services by 50% by March 2024.**
- **Improve the sexual safety of patients and staff on inpatient mental health units and within learning disability services by 50% above baseline by March 2024.**

(NHS England 2023)

Secure Care UK will monitor all episodes of restraint and self-harm, applying proportionality to the review and liaising with our ICB and Trust partners to improve patients experience of care. We practice in line with the Mental Health Units (Use of Force) Act (2018) and the N.I.C.E 10 Guidelines.

Sexual safety as a national priority, is also applicable to ambulance services. Any incidents of a sexual nature will automatically be catagorised as a safeguarding and will be managed through our safeguarding process. To date, there have been six safeguarding disclosures of a sexual nature.

Our Patient Safety Incident Response Priorities

Emerging from data-driven analysis, SCUK's patient safety response strategy crystallizes around paramount themes. The nexus between these themes, the identified risks, and the corresponding planned responses are encapsulated below:

Key Theme	Key Risks from Activity	Planned Response	Anticipated Improvement Route
Use of non-standard restraint	Although there have not been any significant incidents involving the use of non-standard restraint, we acknowledge that this is a high-risk area for our patients. The use of non-standard restraint holds risk to the patient in that the methods used may result in serious injury or harm. Whilst we recognise that our staff have the right to protect their own life and limb, and that in the most extreme circumstances the use of a non-standard restraint may be the only available option, all uses of these restraints require a robust review in line with PSIRF.	**PSII Restraint Monitor SCAAR **ROC **CQC/LADO/Safeguarding	Service Development and Training to lead
Team Hurt	Team hurt, although not directly affecting patient safety holds vicarious impact on patient safety. Our staffing is provided to ensure the safe care of a patient and when a staff member is injured the affects the ability to intervene with risk behaviours.	**PSII SCAAR **ROC	Care Operations Manager led at local level

The use of Positive Handling	The use of positive handling, and the use of mechanical can be necessary within the environment that our staff operate, and the use of restrictive intervention holds an inherit risk. The use of this intervention is predominantly to prevent risk behaviours (such as violence or self-harming behaviour) by the patient which could lead to a more substantial patient safety incident.	**PSII Restraint Monitor SCAAR **ROC **CQC/LADO/Safeguarding	Service Development and Training to lead
Self-Harm	Owing to the specialist service that SCUK provide, we encounter patients who exhibit self-harming behaviours on a regular basis. As in theme 4 staff are trained in the use of positive handling and are able to use this to attempt to prevent such behaviours. However, the nature of harm can mean that acts are performed before physical intervention can be taken, and in line with our requirements under the RRN the use of physical intervention must be 'last resort'. We record 2 incident types around this, 'self-harm' attempt' and 'self-harm actual'. When the patient has achieved harm, we must seek to understand the factors that led to this incident.	**PSII SCAAR **ROC	Care Operations Manager led at local level

Absconding Patient	The patients we provide service to are predominantly detained for a legal perspective, as such they have restrictions as to where they may go. On the occasions where a patient manages to abscond from our team there is a risk to that person's safety and potential risk to others. SCUK staff as mentioned above are trained in the use of physical intervention to prevent the absconding and in the cases that this is not successful, we seek to understand why, the potential risk and the actual risk, to ensure appropriate learning.	**PSII Restraint Monitor SCAAR **ROC **CQC/LADO/Safeguarding	Care Operations Manager led at local level

***due to the nature of the incidents these may have an actual harm level anywhere between none and mortality. Due to this our response will be proportionate to the potential and actual harm, as well as considering trends and other systems approach criteria. The actions marked with the ** mean that they may or may not be necessary and may be completed to varying levels in line with this proportionate response.*

Safeguarding

Safeguarding remains one of our key focus areas and is a process that will continue to be managed in the current form, as set out below.

Incidents that are identified by the crew as safeguarding concerns trigger an immediate text alert to the senior leadership team. These alerts serve as an early-warning mechanism, allowing for timely attention and necessary actions. The senior leadership team conducts thorough reviews of the incidents to assess their nature and severity.

Following the review, incidents are reported to the relevant local authority and the Care Quality Commission (CQC). This reporting process facilitates open communication and transparency with regulatory bodies, ensuring compliance with industry standards and regulations.

In cases where reported incidents exhibit elements of safeguarding, such as instances involving restraint, additional measures are taken. These incidents are promptly reported

to both the local authority and the CQC, reinforcing Secure Care UK's dedication to comprehensive reporting and proactive intervention.

Furthermore, Secure Care UK commits to respond to all statutory enquiries (S42,S47) in the timeframe set out by Local Authorities.

The core value of "patient first" is evident in Secure Care UK's approach, as the organisation upholds the six principles of safeguarding, prioritising the well-being and security of those under its care. This commitment is reflected in both the proactive measures taken and the collaborative efforts with regulatory bodies.

Engaging with those involved in a patient safety incident.

The PSIRF recognises that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. The PSIRF supports development of a patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents. 'Those affected' include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.

Secure Care UK has established several support mechanisms for staff involved in incidents; our incident reporting and triaging processes, along with our 24-hour Control Room enable staff to be responded to quickly following an incident. As part of our response to incidents, we have a process for welfare meetings and engagement with immediate line management. We also have an Employee Assistance program that can be accessed anytime and a confidential Whistleblowing Line. However, owing to the operational nature of our facility, we frequently lack access to patient contact information. Consequently, we will collaborate closely with ICBs and NHS Trusts, including specific units, to facilitate communication and provide assistance to patients and their families when necessary. We will seek engagement from all those affected by safety incidents, not only in the review of care, but also in the determination of learnings and service improvement.