# Patient safety incident response plan

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| | NAME | TITLE | DATE |
|---|---|---|---|
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# Contents

## Introduction

This patient safety incident response plan sets out how Beacon Medical Services Group (BMSG) 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.

<u>This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed alongside BMSG's Adverse & Patient Safety Incident reporting policy which defines the processes for reporting all adverse and patient safety incidents.</u>

## Our services

BMSG are an independent healthcare provider commissioned by the NHS to provide community-based services across Greater Manchester, Greater Preston, South Ribble and Chorley. We offer the following services:

- Non-Obstetric Ultrasound scans
- Ear, Nose and Throat
- Minor Surgery
- Gastroenterology/Endoscopy
- Audiology
- Magnetic Resonance Imaging (MRI) scans

## Defining our patient safety incident profile

This patient safety incident response plan (PSIRP) sets out how BMSG will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care that we provide. This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a.  refocusing PSII towards a systems approach[1] and the rigorous identification of interconnected causal factors and systems issues

b.  focusing on addressing these causal factors and the use of improvement strategies to prevent or continuously and measurably reduce repeat patient safety risks and incidents

c.  transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents

d.  demonstrating the added value from the above approach.

## Stakeholder engagement

- Clinical & Administrative staff- Engagement through regular feedback (including findings from patient experience, incidents and complaints monitoring) to gather insights on patient safety issues and improvement strategies.

- Senior Managers- Involvement in planning and implementing safety protocols and ensuring compliance with safety standards.

- Patients and Families- Provision of several mechanisms for patients and families to share their experiences and suggestions for improving safety.

- Regulatory Bodies- Compliance with requirements of Care Quality Commission to ensure compliance with national safety standards and incorporate their guidelines into the PSIRP alongside service specific regulatory body's standards for a safe, high quality service.

- Commissioners- Incorporation of recommendations from Integrated Care Boards (ICBs) into PSIRF framework and plan to ensure a coordinated and comprehensive approach to patient safety

*Patient safety incident response plan Reviewed December 2025*

## Data sources

- Incident Reporting Systems-Internal Reporting System to collect data on patient safety incidents.
- National Databases- Access to report incidents/events on the Learning from Patient Safety Events Service (LFPSE) alongside FutureNHS platform for guidance and policy development
- Patient Records and Clinical Data- Utilise Electronic Health Records to identify patterns and root causes of safety incidents.
- Clinical Audits- Conduct regular clinical audits to assess compliance with safety protocols and identify areas for improvement.
- Surveys and Feedback Mechanisms-Use of Patient Satisfaction Surveys/Complaints monitoring to gather patient feedback on their experiences and perceptions of safety.
- Staff Feedback-Collect feedback from all staff through surveys and 'open door' approach to identify potential safety issues.
- Regulatory and Compliance Data- Review inspection reports and Accreditation standards/recommendations from the CQC and service specific Regulatory bodies to identify areas needing improvement.
- Compliance Audits- Conduct internal audits to ensure adherence to safety regulations/standards and mandatory training requirements

## Service improvement and transformation

There are currently workstreams in place across the Organisation to support patient safety. These are aligned with national requirements and are internally developed and led under the umbrella of the Organisation's

*Patient safety incident response plan Reviewed December 2025*

Quality locally driven improvement and service transformation programmes).

- Quality Improvement Framework: Creation and Implementation: Developed a comprehensive quality improvement framework that includes specific quality improvement plans. Current Quality Improvement plans (QIPs) are underway for identified key areas such as appropriateness and timescale of follow up appointments, communication systems for discharge letters.

- Ongoing Rolling Audit Programme: Established a rolling audit programme to continuously monitor and assess the effectiveness of safety protocols and identify areas for further improvement. This is an ongoing measure which can be adapted dependent upon the result of audit whereby specific QIPs can be instigated as and when required.

- Organisational Risk Register: Regular Review and Update: Implemented a process for regular review and update of the organisational risk register to ensure all potential risks are identified, assessed, and mitigated.

- Patient and Family Engagement: Revised patient experience data collection system to increase the response rate to provide a broader and more accurate dataset, allowing us to make more informed decisions and improvements based on comprehensive feedback.

- Technology Integration: Enhanced use of automation to improve accuracy in data input and output, providing timely and accurate data.

- Staff Training and Education: Continuous education through the provision of ongoing training and education for healthcare staff on the latest patient safety practices and protocols which are linked to the current mandatory e-learning system.

## Defining our patient safety improvement profile

Based on the findings from our service mapping exercise it is more appropriate to include one table for our organisation owing to the safety incidents being relative across most if not all services. This ensures clarity in the strategy across the Organisation.

## Our patient safety incident response plan: national & local requirements

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The patient safety incident types relative to our services are shown in the table below

| Patient safety incident type | Required response | Anticipated improvement route |
|---|---|---|
| Incidents meeting the Never Events criteria e.g. Surgical errors (wrong site surgery) | PSII | Local organisational actions and feed these into the quality improvement strategy |
| Death of service user (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)) | PSII | Create local organisational actions and feed these into the quality improvement strategy |
| Medication errors (incorrect dosage/use of sedation reversal agent)<br><br>Adverse drug reaction (anaphylaxis) | PSII/Root Cause Analysis (RCA)<br><br>Medication Safety/Safe Sedation policy review | Board level review of PSII and RCA to determine policy change/service management/staff training & development. |
| HAIs | PSII/RCA<br><br>Infection control review | |

*Patient safety incident response plan Reviewed December 2025*

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|---|---|---|
| Diagnostic errors (misdiagnosis or delayed diagnosis leading to harm) | PSII/RCA Image/report review (internal/external to be determined) enhanced audit & monitoring | Reporting via LFPSE |
| Patient identification errors (leading to incorrect treatment) Communication errors (mis communication) Administrative errors (incorrect scheduling/documentation of test results) | PSII/RCA Patient verification process review Electronic record review | |
| Equipment failures (malfunction causing harm) | PSII/RCA Equipment inventory/service schedule review/Medical devices policy | |

### Evaluating and monitoring outcomes of PSIIs & RCA

Robust findings from PSIIs and reviews provide key insights and learning opportunities. These findings must be translated into effective improvement design and implementation.

In line with the Organisational QI Framework, improvement work will only be disseminated 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/undesired outcomes.

These will be included in the Quarterly Governance meeting as a standard Agenda item. The reports will include aggregated data on:

*Patient safety incident response plan Reviewed December 2025*

- patient safety incident 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/staff via the Patient Experience report

- results of surveys and/or feedback from staff