Patient safety incident response plan

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	NAME	TITLE	SIGNATURE	DATE
Author	**LAUREN CAMPBELL**	**MANAGING DIRECTOR**		**15/07/2024**
Reviewer	**JOANNE PILLING**	**OPERATIONS LEAD**		**15/07/2024**
Authoriser	**DR RASHAD NAZIR**	**CEO**		**15/07/2024**

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Introduction

This patient safety incident response plan sets out how Optimise Healthcare Group 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.

Our services

We provide a service based on current evidence and best practice for a variety of mental health conditions.

We provide assessment and treatment for the following conditions.

- Depression
- Anxiety
- Obsessive Compulsive Disorder
- Bipolar Disorder
- Post Traumatic Stress Disorder
- Addictions
- Attention Deficit Hyperactivity Disorder
- Autistic Spectrum Disorder
- Mood Disorders
- Personality Disorder
- Eating Disorder

Treatments include:

- Repetitive Transcranial Magnetic Stimulation (rTMS). NICE has recommended this treatment for depression since 2015. It is widely available in the USA, across Europe Asia and Australasia for over 10 years.
- Psychotropic Medications
- Esketamine Nasal Spray

The Clinics at Optimise Healthcare Group in Warrington and Liverpool cover the UK population and is accessible to all patients who are of informal status and capable of giving valid informed consent.

Services Provided for Patients Aged 4-12;

- Psychiatric Assessment and Diagnosis
- Psychological Therapies

- Psychotropic Medications

Services Provided for Patients Aged 13-18;

-Psychiatric Assessment and Diagnosis

-Psychological Therapies

-Psychotropic Medications

-Transcranial Magnetic Stimulation (TMS) for Treatment Resistant Depression (TRD)

Services Provided for Patients Aged 18+

-Psychiatric Assessment and Diagnosis

-Psychological Therapies

-Psychotropic Medications

-Transcranial Magnetic Stimulation (TMS)

-Esketamine Nasal Spray

Defining our patient safety incident profile

In order to define our patient safety profile we asked ourselves

"What are the main incidents we may come across as a relatively new service?"

and

"What incidents have occurred that we can use to help inform system improvement?"

Our incident response activity has been very minimal, proportionate to the size of the organisation, with no serious incidents yet reported. There has been little to draw from thus far. However, we have looked into common incidents across similar organisations to help us develop our patient safety plan.

We engaged with ICB and commissioning staff across our contracted service areas and discussed our internal risk log and wider risks that could affect our service delivery and patient safety.

Defining our patient safety improvement profile

Our top patient safety priorities include;

1. Risk rating: regularly reviewing patient risk within the service and making these risks more visible within our systems
2. Communication with primary care. We are working on an individualised system which allows our organisation to improve communication with primary care services across the UK.
3. Medication management incidents. New systems being developed to help prevent medication prescribing errors and near misses.

In order to identify the main priorities within the patient safety profile, we have discussed amongst the senior leadership team the main areas of concern. These have primarily been regarding level of information regarding patients on referral, leading to increased risk due to unknown key information. There is a lack of assessment of patient risk on referral which makes it difficult to prioritise based on risk and puts increased pressure on services and patients. The technology system being developed will require a minimal level of data input on referral and will generate an automated risk rating based on internal criteria. This will allow the service to act within an appropriate timeframe and categorise patients more effectively.

Our emphasis is on improving the systems and technology which will not only make the patient pathway safer, but also improve the patient experience.

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response
Incidents meeting the Never Events criteria 2018	PSII
Eg death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII
Safeguarding incidents in which: • 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 FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead 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 board

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Communication with primary care	Develop systems and technology to further improve this communication electronically and allow appropriate access to patient records for NHS funded private services	Create local safety actions and feed these into the quality improvement strategy
Medication prescribing errors	New staff appointed to ensure further checks carried out on prescriptions and training delivered to staff where errors have occurred. Systems are currently being developed to automate much of the causes of the errors and alert staff prior to the error occurring.	Identify appropriate training for staff and continue to develop internal systems.
Risk rating	Automated RAG rating system being developed for new referrals, allowing staff to appropriately categorise patients. System being developed allowing alerts of RAG rating on the system with risks identified more easily.	Continue to develop systems and standardise risk rating system.