KSS Standard Operating Procedure

SD SOP 23: Patient Safety Incident Response Plan

SOP name	SD SOP 23: Patient Safety Incident Response Plan		
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Version number	Revision Date	Nature of Revision	Next Review Due
1	19/10/23	Initial draft	1/8/2025
2	11/12/24	Interim review following first 12 months of PSIRF implementation	1/12/2025

Audience	All staff
Public facing SOP (yes/no)	Yes

Related Policy Statement

Air Ambulance Charity Kent Surrey Sussex (KSS) is committed to continuously striving for excellence with regards patient safety, building on the foundations of a safer culture and safer systems so our patients are protected from avoidable harm.

KSS are committed to adopting the NHS Patient Safety Incident Response Framework (PSIRF) as a tool for developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Purpose

The purpose of this SOP is to set out how Team KSS plans to implement the NHS Patient Safety Incident Reporting Framework (PSIRF) to continue to support the journey of systematic patient safety improvement.

- The objectives are:
- To ensure stakeholder input and engagement in improving system learning from patient safety incidents
- To utilise improvement plans to prevent or continuously and measurably reduce patient safety risks and incidents

- To maintain focus on understanding causal factors and system issues both locally but also nationally through collaborating with other Air Ambulances

Background and Scope

The Patient Safety Incident Response Framework (PSIRF) sets out the approach of the NHS to developing and maintaining effective systems and processes for responding to incidents for the purpose of learning and improving patient safety. The Patient Safety Incident Response Plan (PSIRP) has been created based on a patient safety risk profile of previous incidents, reported by staff, patients and/or their families, carers or other organisations. The plan sets out how Team KSS prioritises a co-ordinated, data-driven approach to patient safety incidents, responding compassionately and proportionately to these. Team KSS remains flexible in considering the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

Team KSS, working closely with colleagues in the aviation industry, has historically valued a system and processes approach in learning from incidents. KSS is committed in continuing to improve its culture in engaging compassionately with those involved in patient safety incidents, applying lessons learnt on a system-wide level, responding considerately and proportionately, with a supportive oversight focusing on system improvement.

Mapping our Services

At Air Ambulance Charity Kent Surrey Sussex (KSS) we fight every day to save lives. We are Team KSS, a close-knit team of dedicated, skilled, sector-leading experts with an incredible level of expertise. We are passionate about what we do which drives us to always deliver our very best. We're driven by our purpose of saving lives and ensuring the best possible outcomes for our patients. In 2023, we responded to over 3,200 incidents by air and road, 24 hours a day. These emergencies are both of a medical and traumatic nature for patients of all ages, in the Kent, Surrey and Sussex. KSS provides mutual aid as well, supporting surrounding counties and Air Ambulance Services. The headquarters and forward operating base are located at Rochester Airport, with our aircraft hangared and maintained at Redhill Aerodrome. When the call comes, we can reach any part of Kent, Surrey or Sussex in under 30 minutes by air.

The process of mapping the KSS Services begins by looking at the patient journey from emergency call to discharge home from hospital. A 999-emergency call is made and the call taker at the local Ambulance Service Emergency Operations Centre establishes the nature and urgency of the incident, which is graded to establish the nature of the ambulance response. A KSS Emergency Operations Centre dispatcher keeps a close eye on 999 calls coming in and will dispatch, where appropriate, a KSS crew by air or road to the incident. On many occasions, prior to the KSS crew's arrival, the patient will have been attended to by paramedics and ambulance staff of the local Ambulance Trust, South East Coast Ambulance Service NHS Foundation Trust. The KSS team, including a doctor and paramedic, integrates and works closely with the ambulance crews to achieve the best possible patient outcome. Once treated and triaged by the prehospital team, the patient is transported to the appropriate hospital, which in a majority of the cases is a specialist centre. This begins the

patient's hospital journey which can be a time period of days up to months and even years.

Occasionally, patients are in contact with KSS through the Patient and Family Aftercare Service which delivers a pastoral, holistic aftercare service to former patients who have received care from KSS. This aftercare extends to patients, their families, bereaved families, emergency service colleagues and bystanders supporting their journey of recovery.

In order to deliver excellent critical care, KSS works collaboratively not only, but also with the local Ambulance Trust, other UK Air Ambulances, local coroners, hospitals and patient engagement forums.

Definitions

Standard operating procedure (SOP)	Detailed operational procedure outlining how the organisational policy will be implemented.
KSS Staff	Any individual who works for KSS in any capacity including Emeritus staff and those working on a full-time, part-time, temporary, secondment, or line share basis.
Patient Safety Incident	Defined as any unintended or unexpected occurrence that could have or did lead to harm for one or more patients
PSIRF	A national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.
PSIRP	Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a co-production approach with the divisions and specialist risk leads supported by analysis of local data.
QIP	Quality Improvement Project

Application

A Patient Safety Incident (PSI) is defined as any unintended or unexpected occurrence that could have or did lead to harm for one or more patients.

The response plan is detailed in figure 1 and categorises an incident as national priority, KSS Focus or Priority, or other. These categories are all further detailed in separate chapters of the PSIRP. With a relatively small number of patient safety incidents historically, Team KSS will be trialling the use of the different types of responses during the implementation phase of PSRIF but remains flexible and agile.

As per the figure, each category has a pre-planned response, including external referral and internal such as After Action Review (AAR), Multi-Disciplinary Team (MDT) review, thematic review and Patient Safety Incident Investigation (PSII).

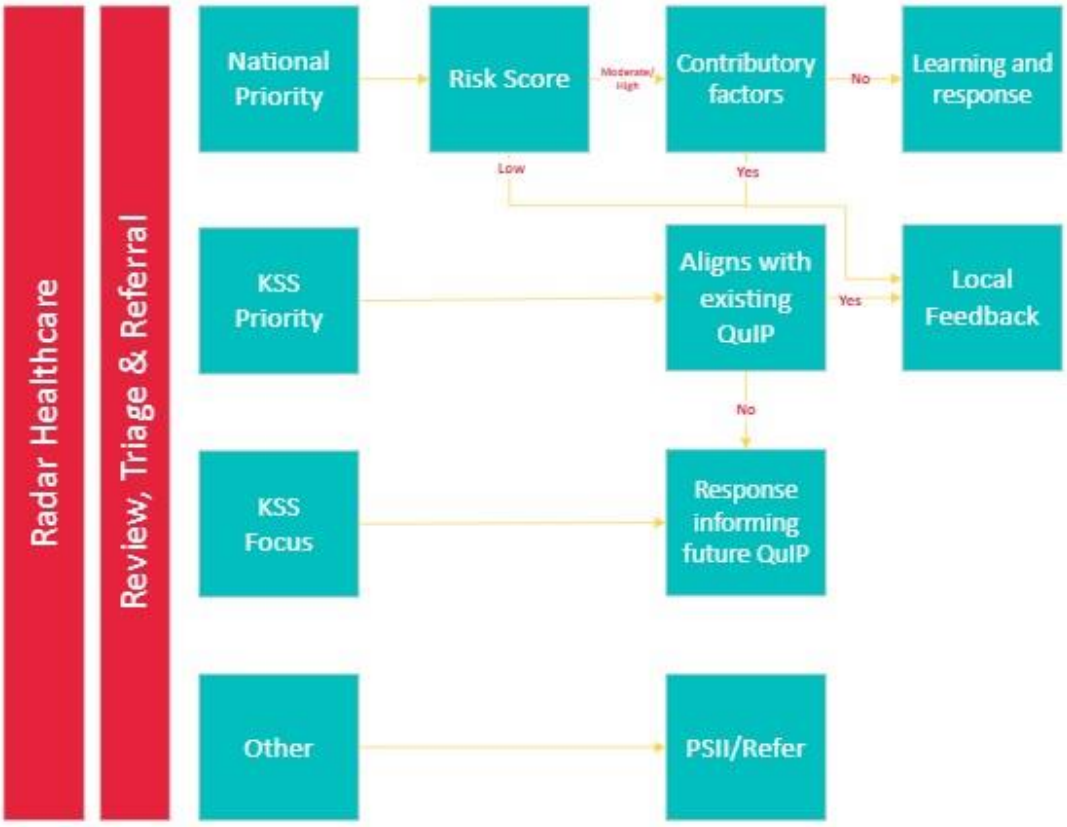


Figure 1 KSS response plan

Response types

An AAR is a structured and facilitated group discussion after any activity or event that has been particularly successful or unsuccessful. The intent is to include as many people as possible who were involved in the activity or event so that a wide range of viewpoints can be explored. The review is to provide an understanding and learning to improve practice by understanding why the outcome differed from that expected. The AAR is to be facilitated by a trained and competent investigation lead with the learning recorded in a standardised manner through and AAR report and actions recorded on the electronic compliance system.

A MDT review is an in-depth process of input from several different disciplines in identifying learning from multiple PSIs and explore improvement themes, pathways or processes. These may involve collaborating with key stakeholders outside of Team KSS, involved in the patient journey and care. An MDT review is to be facilitated by a trained and competent investigation lead with the learning recorded in a standardised manner.

A PSII is an in-depth review of a single patient safety incident or cluster of events to understand what happened, and how. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time. A PSII is required where an incident results in moderate or severe harm to patient resulting in a statutory duty of candour notification but can be carried out in any other PSI where deemed a helpful tool in understanding the incident further. The PSII is to inform a thematic analysis of ongoing patient safety risk and to be used to

build a case for a improvement or inform ongoing improvement efforts. The PSII is to be carried out by a trained and competent investigation lead learning recorded in a standardised manner and actions recorded on the electronic compliance system.

A no/low harm patient safety incident is to result in a validation of the facts at a local level through a thematic review, also to inform ongoing patient safety risks and improvement efforts. The thematic review is to be carried out by a trained and competent investigation lead with the learning recorded in a standardised manner and actions recorded on the electronic compliance system.

Engagement principles

The principles by which Team KSS aims to engage with individuals affected by PSIs are:

- striving for equity in learning from PSIs balanced against the needs of the affected individual(s)
- accepting subjectivity in that everyone's experience is a credible source of information
- allowing those affected to feel and be heard
- open and collaborative process with guidance and clarity provided with clear and regular engagement points with all involved parties
- sensitivity to timing of involvement
- respect and compassion for those affected
- individual approach where apologies are deemed meaningful
- being open and transparent with the people affected, whether or not something has gone wrong

Supporting staff involved in PSIs

At the core of Team KSS is debriefing incidents, both formally and informally. The crews attend high-pressure, high-stake incidents, which are often emotive and requiring high levels of Crew Resource Management skills. Essential to developing these skills, alongside medical skills and interventions, is to reflect with the team present on the incident, considering the aspects which have gone very well as well as aspects requiring development. This occurs through informal "coffee and cases" during the shift where there may or may not be senior input through Duty Clinical Managers (DCM) or Governance Leads (GL). More formally, this occurs through Clinical Governance, with Clinical Managers, Governance Lead and clinicians present. Incidents both flagged by independent reviews or clinicians themselves, are reviewed and learning points summarised. Each Service Delivery team member is scheduled onto these Clinical Governance days regularly (bi-weekly if full-time employee) and these discussions are disseminated to all clinical staff to ensure system learning.

If any staff member is experiencing difficulties following a PSI, the line manager should offer immediate support. For front-line clinicians this is the DCM who in turn can be supported by the Tactical-on-call.

Engagement and Investigator leads, trained within the PSIRF framework, are to be involved on the initiative of the DCM. Engagement Leads maintain regular contact (fortnightly at a minimum) with all staff involved in the PSI, until such time as the Patient Safety Review Panel is satisfied and the response is completed. Investigation Leads are responsible for ensuring that staff are given the opportunity to debrief following a patient safety incident, irrespective of severity, and that staff are informed of how to access counselling services and additional support.

This list of actions available for various managers or individuals to take if the staff member is experiencing difficulties associated with the event include:

- Occupational Health Services
- Employee Assistance Scheme/CIRION counselling
- Trauma Risk Management (TRiM)
- Leave of absences
- Staff/peer support

Duty of Care, Duty of Candour and Just Culture

At the core of Team KSS is our Duty of Care and Candour, including a commitment to engage compassionately with all involved parties of the incident: patients, their families, and staff. The KSS culture is to be honest with our patients, informing them of any moderate or serious patient safety incident in which they have been involved. By being open, KSS commits to acknowledge that the incident has occurred, apologise to the patient or next of kin, explain why the incident occurred and what actions will be put in place to prevent reoccurrence. KSS encourages this culture in communicating honestly, accurately, and in a timely fashion with patients and their family members and/or representatives following a patient safety incident. By engaging those affected, a better understanding of the incident can be gained, therefore informing potential means of preventing similar incidents in the future.

Each PSI is initially triaged, including level of perceived harm, and any low or above level of harm will trigger an automated compliance workflow step for a Duty of Candour review by the Caldicott guardian. Team KSS continues to commit to the principles Duty of Care and Candour throughout the implementation of PSIRF accepting that transparency to patients, family and staff encourages the concept of shared accountability in the choices that affect safety and quality of care.

KSS supports the principles of fair blame and promotes a Just Culture where incidents, including complaints and claims, can be reported and investigated in a non-punitive and supportive environment to ensure that investigations identify whether the actions of individuals were due to systems failures or whether the individual knowingly committed a reckless intentional unsafe or criminal act. This culture is not only seen through policies and procedures but evidenced by the high incidence of incident reporting culture. In 2023, there were 705 incidents reported in the Service Delivery directorate. With approximately 90 members in the service delivery team, including paramedics, doctors, dispatchers and non-clinical staff, the incident-to-staff-ratio is high, indicative of a healthy reporting culture (Howell et al., 2015).

Within the first year of implementing PSIRF, the recorded incidents in relation to patient safety have grown, indicative of a positive reporting culture.

Also, the positive reporting culture is evidenced in the non-technical skills that the medical and aviation teams continue to carry out in their daily duties, regular clinical governance meetings with debriefs and discussions as well as twice yearly crew courses where the learning is embedded in new staff by an experienced faculty.

The principles of Duty of Candour, Just Culture and Duty of Care are also incorporated into the annual statutory and mandatory training for both operational and non-operational staff and outlined in more detail in the Service Delivery Standard Operating Procedure 03: Being Open and Duty of Candour.

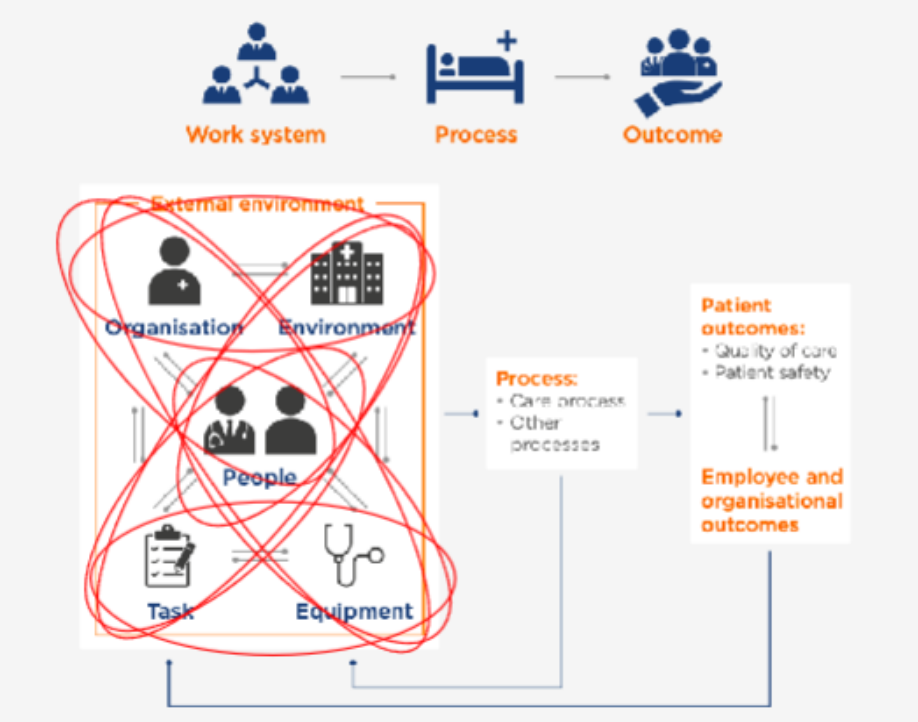
Cross-system learning

Team KSS is committed to sharing the learning from PSIs both internally and externally. Whether this learning originated from response types, clinical governance discussions, PSIIs or elsewhere, the learning is to be disseminated across the whole service delivery team through CG meeting notes and a quarterly bulletin on PSIs.

The Patient and Family Aftercare Service is another opportunity for learning and has been extended to patients and shared back to clinicians through patient visits. KSS is also committed to learning with and from Air Ambulance Services, both nationally & internationally in understanding mutual patient safety risk.

KSS has adopted the Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon et al., 2006) pictured below in learning from PSIs. SEIPS is a framework for understanding outcomes within complex socio-technical systems. The SEIPS framework acknowledges that work systems and processes constantly adapt, where the patient outcome is not only driven by the process prescribed organisationally, but the work done including other areas like the environment, people, eQIPment, organisation, and task. The work systems influence the work prescribed i.e., the process, which in turn results in demonstrable improvement in patient outcome. A work system consists of six broad elements: external environment, organisation, internal environment, tools and technology, tasks and person(s).

The key principle is that people cannot be separated from the work system; their deliberate placement at the centre emphasises that design should support, not replace or compensate for, people.



Picture 1 SEIPS model

Assurance and monitoring

The platform for reporting patient safety incident in KSS is through the internal electronic incident reporting system in line with SD SOP 06 Incident Reporting and Investigation. All incidents are reviewed by the duty Tactical-on-call within 24 hours, triaged and risk scored by likelihood and consequence. If categorised as a PSI, this will be referred to the PSIRF lead and patient safety review panel (figure 2).

Figure 2 Patient Safety Review Structure

Any complaint or concern reported anonymously will automatically trigger a PSIRF review if triaged as PSI relevant.

The Patient Safety Review Panel is central in ensuring the dissemination PSIs across KSS. This panel is a diverse group, representing different work systems including staff, patients, service delivery clinical operations managers, Associate Medical Directors, eQIPment and education manager, patient safety lead and executive oversight.

The Patient Safety Review Panel is chaired by the PSIRF lead and meets every eight weeks to review PSIs, collate and summarise learning, as well as communicate this across all systems internally and externally. A risk score of ten or higher, will result in the Tactical-on-call being informed immediately and an Extraordinary Safety Review Panel meeting, where immediate actions such as Duty of Candour, Regulatory notification, or external referral and a communication plan is to be discussed.

The effectiveness of the PSIRP will be monitored by the Patient Safety Review Panel which will report into the Service Delivery Management Team and Executive Senior Leadership Team. The Executive Board will have oversight through a quarterly Clinical, Governance and Service Delivery Committee meeting.

The suitability of the chosen priorities informing the quality improvement work will be under constant review, remaining flexible in the choice of these dependant on incident reporting. Monitoring will also include the stakeholder perception of how appropriate, relevant and compatible the plan appears across KSS. All these are to be incorporated into the Patient Safety Review Panel's Terms of Reference.

The effectiveness of the plan will rely on continued stakeholder engagement, especially internal staff and experiences will be collated and considered going forward.

The KSS Patient Safety Incident Profile

In the early stages of the KSS PSIRF journey, the working group consulted PSIRF early adopters to understand the practicalities of implementing The Framework. Following this, a two-year review of all incidents was conducted to identify patient safety issues pertinent to Team KSS.

Data and incident review

The decision to limit the data reference period to two years was a balance between gaining relevant versus up-to-date data and a quantitative robustness. The internal review was carried out using the internal electronic incident reporting system, where incidents were manually reviewed to identify patient safety incidents using the PSI definition.

The variety of sources to support our data collection included:

- Internal electronic incident reporting system
- Complaints
- Freedom to Speak Up reports

On review, incidents directly linked to patient care were included and reports of incidents noted during routine checks were ruled out. In total, 1559 incidents were reviewed. Out of these, 98 patient safety incidents were identified. A narrative analysis was carried out to code and theme the patient safety related incidents, which partly informed the KSS patient safety profile. In addition to the thematic analysis of quantitative and qualitative data from the internal reporting system, potential key themes from complaints, claims, feedback from staff, themes from learning from deaths, external reviews were reviewed.

Stakeholder engagement

The data review was shared with stakeholders, as summarised in figure 3, through an initial series of engagement meetings, whose engagement helped shape and further inform The KSS patient safety profile. Internally, this included service delivery and non-operational staff, the Senior Clinical Leadership Team, Executive Leadership Team and Executive Board.

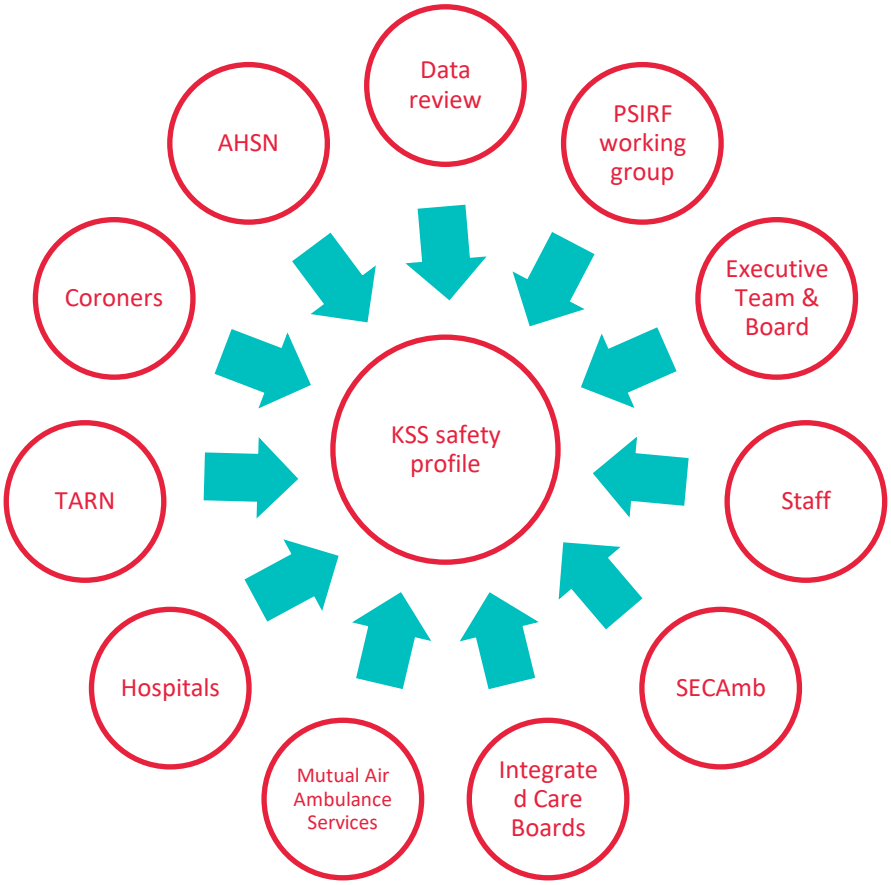


Figure 3 Stakeholder engagement

Consulting Service Delivery staff throughout the PSIRF journey has remained integral in the determining the areas of KSS patient safety focus and priorities. The progress of the framework and plan was regularly discussed at clinical governance, inviting clinicians to join the PSIRF working group and the shaping of the plan. Giving the patients a voice in the shaping of the plan, team members from the Family and Aftercare Service were involved in the working group as well. The outcomes from all these engagement points, along with any other patient safety concerns not highlighted in the review, were collated to support the next stage of the PSIRF process in engaging external stakeholders.

External stakeholders included the local Ambulance Service, Integrated Care Boards, hospitals and Coroners. In addition, the Trauma Audit and Research Network (TARN) was engaged in the safety profiling. Regular meetings were set up with other Air Ambulance Services with emphasis on collaborating in defining the patient safety incident profile. This resulted in noting similar themes across multiple Air Ambulance Services, aiding in the planning of collaborative Quality Improvement efforts. Our local CQC representative was engaged at the

early planning stages and kept up to date through the PSIRP and PSIRF policy approval process. The collective data from all these outlined engagements were reported back to the PSIRF working group which informed the KSS patient safety risk profile.

Patient safety risk profile

The patient safety risks emerging from the narrative data were grouped into codes then into overarching themes. The review yielded six themes with two to four codes within each theme. With the stakeholder engagement, this was further developed into 24 more codes (Table 1). These themes have been agreed to cumulatively become the KSS patient safety focus going forward.

Theme	Code	Stakeholder addition
Equipment	Missing	KSS's own and third-party
	Failing	
	Incorrect use	
Medicines error	Incorrect dose	Supply
	Incorrect indication	
Intervention	RSI	Undetected oesophageal intubation/displacement
	Anaesthetic awareness	Aftercare
	Manual handling	Maternity and neonate
	Cannulation	Safeguarding
Capacity	Missed job	Ambulance Service resourcing
	Staff	Loss of staffing, Staff welfare, fatigue, shift changeover time, staff currency & compliance, training, procedures
	Other	Reputational or financial harm
	Hospital	Major Trauma Centre availability
Aviation	Missed job	Helipad availability
	Delay	Crash, grounding
Communication	Emergency Operations Centre (EOC)	CCD, stand-down, delay pathways, collaboration, inability to interrogate calls
	Handover	Triage & follow-up
	Documentation	

Table 1 KSS Patient Safety Risk Profile

Defining Our Patient Safety Improvement Profile

Quality improvement science is about finding out how to improve and make changes in the most effective way. It is about systematically examining the methods and factors that best work to facilitate quality improvement (Health Foundation, 2011).

Quality Improvement projects and commitments

Over a number of years, Team KSS has developed its governance processes to ensure learning from PSIs which has fed into quality improvement activity. Regulatory, national, and regional NHS guidance, as well as commissioner and partner provider feedback has also continually aided in developing quality improvement work. A summary of existing and future quality improvement work can be found in Appendix 1.

The quality improvement journey is a fluid process, unlikely to be linear. The theoretical framework (picture 2) highlights this process in that it requires constant consultation and review. Therefore, initiating any QIP under the PSIRP includes, most importantly, stakeholder engagement. This process of actively involving stakeholders enables collaboration, as well as understanding system-specific issues represents phase one of the QIP. The latter stages of any PSIRF QIP incudes creating conditions for change, understanding systems, developing short and long-term aims, testing the changes, implementing and finally sharing the learning.

Picture 2 Quality Improvement Journey

PSIRF has provided an opportunity to review existing quality improvement initiatives and highlight potential areas of development through the PSIRF Focus and Priorities categories. A bowtie gap analysis (Wierenga et al., 2009) of these areas of patient safety risk highlights potential gaps or areas of future quality improvement, to inform the decision of QIPs. Team KSS remains flexible and will consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Quality Improvement oversight

Any KSS Service Delivery QIP will be overseen by the Patient Safety Lead, reporting to the Executive Director of Service Delivery. The Patient Safety Lead is to ensure that patient safety investigations are undertaken for all incidents that require this level of response, as directed by the PSIRP. The Patient Safety Lead is to establish procedures to monitor and review quality improvement progress and the delivery of improvements. The Patient Safety Lead is to work with the Service Delivery Executive Director and members of the senior management team to address identified weaknesses/areas for improvement in Team KSS's response to PSIs.

National Priorities

This section sets out the national priorities of patient safety incidents with the required responses in maximising the resources of Team KSS. As shown in table 2 below, some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but KSS fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

Event Type	Required Response	Anticipated Improvement Route
Incidents meeting the Never Events criteria (2018)	Patient Safety Incident Investigation (PSII)	Create local organisational actions and feed these into the quality improvement strategy
Death thought more likely than not due to problems in care		
Deaths of patients detained under the Mental Health Act (1983) or where Mental Capacity Act (2005) applies		
Mental health-related homicides	Refer to the NHS England Regional Independent Investigation Team for consideration for an independent PSII, locally led PSII may be required	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
Child deaths	Refer for Child Death Overview Panel (CDOP) and liaise with panel as locally led PSII may be required	
Deaths of person who has lived with a learning disabilities or autism	Refer for Learning Disabilities Mortality Review (LeDeR) liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required	

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 via MCFT named safeguarding lead who will contribute to 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 the local safeguarding adults boards
Incidents in NHS screening programmes	Work with partners to ensure cases are referred to Public Health England (PHE)
Death in custody/prison/ probation	Refer to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC)

Domestic homicide	Identified by the police usually in partnership with the local community safety partnership with whom the overall responsibility lies for establishing review of the case. Where the CSP considers that the criteria for a domestic homicide review are met and establishment of a DHR panel, MCFT will contribute as required by the DHR panel.	
Maternity and neonatal incident meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA0 criteria when in place)	Refer to HSIC or SpHA for independent PSII	

Table 2 National Priorities

KSS Focus and Priorities

PSIRF encourages to explore patient safety risk relevant to the unique context in which Team KSS operates and the specific population it serves. The KSS Focus and Priorities are determined through the KSS patient safety profile, based on reviewing the ongoing PSI data trend and engaging with stakeholders.

The KSS Focus and Priorities are areas of improvement to provide a strategic direction for the continuous development of patient safety in KSS. The decision-making process to finalise three priorities was made in agreement with internal stakeholders and will constantly be under review by the Patient Safety Review panel for appropriateness, relevance, and compatibility across KSS. The KSS Focus list are areas of patient risk where KSS aims to carry out future quality improvement projects but will in the interim monitor these, and where a new risk emerges or learning, is to aid in the future improvement of these. The KSS priorities are current QIPs which are further outlined in the quality improvement profile section above.

KSS Priorities	Planned Response	Improvement Route
Dispatch & Deployment	Review by patient safety panel and refer to QIP working group	Inform ongoing QIP
Staff Currency & Compliance	Review by patient safety panel and refer to QIP working group	Inform ongoing QIP

Table 3 KSS Priorities

KSS Focus	Planned Response	Improvement Route
Equipment: Missing, Failing, Incorrect Use	Review by patient safety panel for Thematic Review or AAR	Inform future QIP
Medicines Error: Incorrect dose or Indication	Review by patient safety panel for Thematic Review or AAR	Inform future QIP
Intervention: RSI, Anaesthetic Awareness, Manual Handling, Cannulation,	Review by patient safety panel for AAR, MDT or as per SOP 3: Pre-hospital Anaesthesia/anaesthetic awareness	Inform future QIP
Maternity and neonatal incident	Review by patient safety panel and National Priority criteria (QIP concluded in 2024)	Inform future QIP
Capacity: Missed job, Loss of Staffing, Other, Hospital	Review by patient safety panel for AAR or MDT	Inform future QIP
Aviation: Missed job, Delay	Review by patient safety panel for AAR or MDT	Inform future QIP
Communication: Handover, Documentation	Review by patient safety panel for Thematic Review or AAR	Inform future QIP

Table 4 KSS Focus

Related Documents
Patient Safety Incident Reporting Framework Policy SD SOP 03 Being Open and Duty of Candour SD SOP 05 Complaints SD SOP 06 Incident Reporting and Investigation SD SOP 07 Claims Handling Procedure Clinical and Non-Clinical SD SOP 16 Risk Management PSRIF NHSE National Guidance

Responsibilities	
Chief Executive	The overall responsibility for medicines management is with the Chief Executive.

Executive Director of Service Delivery	Day to day management is delegated to the Executive Director of Service Delivery.
Patient safety and compliance lead	To oversee any updates to the plan and liaise with the information governance lead re any policy updates
Managers	All managers within the Service Delivery Directorate are accountable for ensuring compliance with this document.
All Clinicians	Each individual clinician has specific responsibility for their actions to ensure compliance with this document and the reporting of all medicines incidents that they witness. Any failure to comply with this document will be dealt with under KSS' Incident Reporting Procedure, and if required KSS' and Disciplinary Procedures. The process will be a nominated manager from the Service Delivery Directorate and in conjunction with the Medicines Management Lead.

Further reading and references

Carayon, P., Schoofs H. A., Karsh B.Y, Gurses A., Alvarado C., Smith M., Flatley Brennan P., 2006. Work system design for patient safety: the SEIPS model. Qual Saf Health Care 15 Suppl 1(Suppl 1): i50-8.

Health Foundation (2011) https://www.health.org.uk/publications/improvement-science

Howell AM, Burns EM, Bouras G, Donaldson LJ, Athanasiou T, Darzi A. 2015. Can Patient Safety Incident Reports Be Used to Compare Hospital Safety? Results from a Quantitative Analysis of the English National Reporting and Learning System Data. PLoS One.9;10(12):e0144107.

Wierenga, P.C., Lie-A-Huen, L., de Rooij, S.E. 2009. Application of the Bow-Tie Model in Medication Safety Risk Analysis. Drug-Safety 32, 663–673 (2009).

Acknowledgements

Dr Fionna Moore, Senior Medical Advisor

KSS AIR AMBULANCE CHARITY
KENT SURREY SUSSEX

Appendix 1: KSS Quality Improvement Project Profile

Theme	Existing Improvement Project	Future Improvement Project (planned year of commencement)
Equipment	Ongoing improvement initiatives for equipment including procuring best suited equipment, updated guidance, storage, and maintenance agreements as well as ongoing quality assurance audit. Resilience, training, and redundancy with daily, weekly, and monthly checks.	Future incidents and responses to inform future QIPs
Medicines error	Ongoing educational initiatives for medical incidents, training, two-person check culture, consultant pharmacist reviewing SOPs/drug cards	Future incidents and responses to inform future QIPs
Intervention	Ongoing improvement initiatives for skills including RSI, arterial cannulation, anaesthetic awareness etc., Education and Prevention project, Patient and Family Aftercare Service	Maternity QIP (2023-2024)
Capacity	Fatigue QIP, Joint Enhanced Care Team QIP, ongoing initiatives including demand-capacity matching, mixed staffing model, supply agreements, ongoing projects including wellbeing hub, REACT, rest facilities	Currency and Compliance QIP (2023-) Coffees and Cases QIP (2024-) Future incidents and responses to inform future QIPs
Aviation	Ongoing collaboration with provider and pilots	Future incidents and responses to inform future QIPs
Dispatch	Ongoing training of reenforcing purpose, joint logs between Enhanced Care Teams	Future incidents and responses to inform future QIPs
	Initiatives introducing community landing site map on ambulance devices	Dispatch QIP (2023-2024) Dispatch and Deployment QIP (2024-) Future incidents and responses to inform future QIPs

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