POLICY TITLE: **Patient Safety Incident Response Policy (PSIRF)**

POLICY NUMBER: **2.40**

Is this a new policy: **Yes** ☒ **No** ☐

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1. Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the Hospice's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and concerns for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety concerns
- supportive oversight focused on strengthening response system functioning and improvement

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across LOROS Hospice.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope this policy:

- claims handling
- human resources investigations into employment concerns
- professional standards investigations
- estates and facilities concern
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations
- complaints (except where a significant patient safety concern is highlighted)

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

3. Definitions

PSIRF - Patient Safety Incident Reporting Framework
PSI - Patient Safety Incident
PSII - Patient Safety Incident Investigation
ICB - Integrated Care Board

4. Oversight and Responsibilities

The Director of Care Services and the Clinical Quality and Patient Safety Lead are responsible for oversight of the PSIRF.

All PSIIs, safety action plans and any learning will be shared with the Clinical Governance and Development Committee for assurance.

PSIIs, safety action plans and learning are also shared with the ICB and at the monthly Patient Safety Improvement Network (PSIN) meetings.

5. Our Patient Safety Culture

LOROS strives to be an organisation that promotes a climate that fosters a just culture, where our staff feel safe to speak up and to share concerns so that we can work together to improve patient safety concerns. We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk.

All staff are able to report incidents on Sentinel (incident reporting system hosted by Vantage).

6. Addressing Health Inequalities

LOROS is committed to ensuring that our services address health inequalities, this will follow through into our PSIRF approach. We will explore and respond to any emerging concerns related to health inequalities as part of our policy and plan.

7. Patient Safety Partners

LOROS Hospice is a (non-NHS) organisation with a large representation of volunteers, over 1,200 and has an active Hospice User Group (HUG) and membership consists of patients and carers. The Hospice engages with the Hospice User Group (HUG) to ensure the patient and carer voice is represented across the organisation.
Members of the HUG use their lived experience as a patient, carer or family member to support and advise on activities, initiatives, projects and patient information that will improve patient safety and help the Hospice to deliver high quality of care.

8. Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). We will work with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

9. Patient Safety Incident Response Planning

PSIRF supports organisations to respond to incidents and safety concerns in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

9.1 Resources and training to support patient safety incident response

As agreed with the ICB, all clinical staff are required to complete the patient safety training which covers the basic requirements of reporting, investigating and learning from incidents (Levels 1 & 2). Further training will be accessed via the ICB or E-Learning for Health as the need arises.

10. PSIRF plan

Our PSIRF plan sets out how LOROS intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

10.1 Review of the PSIRF Plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders (including the ICB) to discuss and agree any changes made in the previous 12 to 18 months.

Reviewed and updated plans will be published on our website, replacing the previous version.

11. Responding to Patient Safety Incidents

All staff are responsible for reporting any potential or actual patient safety incidents onto Sentinel (the Hospice incident reporting system) and will record the level of harm they know has been experienced by the person affected. This is in line with the Hospice Management of Clinical Incidents Policy.

11.1 Patient safety incident response decision-making

The Hospice has review mechanisms in place, such as the weekly significant events meeting to ensure that patient safety incidents are discussed and responded to proportionately and in a timely fashion. This includes consideration and prompting to teams where Duty of Candour applies, see 2.37 Duty of Candour - Being Open and Honest policy.

Most incidents will only require local review within the service, however for some incidents, where it is felt that the opportunity for learning and improvement is significant and which appears to meet the requirements for reporting externally, these must be escalated to the Director of Care Services. Please also refer to the Management of Clinical incidents policy.

11.2 Responding to cross system incidents/issues

LOROS will also work in a transparent and collaborative way with the ICB if an incident meets the national criteria for PSII or if supportive coordination of a cross system learning response is required.

Where the nature of an incident is multi-organisational LOROS will identity the lead organisation to coordinate the investigation and involve relevant system partners, including patient representatives or family members. Where required LOROS will participate in, and contribute to whole system reviews.

11.3 Timeframes for learning responses

Incident response timeframes should not exceed 60 days.

11.4 Safety action development, improvement plans and monitoring improvement

A bespoke approach will be taken for each individual safety improvement plan, dependant on the available data, stakeholder views, improvement priorities, patient safety incident profile and any insight from the patient safety incident response.

Monitoring and progress of safety actions will take place at the weekly significant events meetings.

12. Complaints and Appeals

The Hospice encourages patients, families or carers to raise any concerns they may have immediately and at the time they occur by speaking to a member of staff.

Any concerns or complaints raised about a service provided by the Hospice are taken seriously managed as outlined in the Hospice's Complaints Policy.

13. Due Regard

As part of its development, this policy and its impact on equality have been reviewed in line with the Equality Act (2010). The purpose of the Equality Impact Assessment is to ensure that there has been due regard given to the protected characteristics to minimise and wherever possible, remove any disproportionate impact on individuals. The protected characteristics are as follows; age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

14. References

NHS England Patent Safety Incident Response Framework