| Patient Safety Incident Response Framework Policy | |
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| Author | Quality Improvement Lead |
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**A.S.P.I.R.E.** (created by staff forum on behalf of all staff at Prospect Hospice)
**A**uthentic - **S**pecialist - **P**erson Centred - **I**nclusive - **R**esilient - **E**xcellent
These values and associated behaviours underpin everything we do and the way we work at Prospect Hospice and all employees are expected to abide by them.

**Equality Impact Assessment**
No one will be disproportionately affected or disadvantaged.

Policy: Patient Safety Incident Response Framework Policy

| Version Number | Amendment History | Author of Update | Page/Section Number | Date |
|---|---|---|---|---|
| V-CG-213 v.01 | New policy | Naomi McKenna, Quality Improvement Lead | Throughout | October 2023 |

## 1 Purpose and Scope

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

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. There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy. 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.

This policy is a Hospice - wide document and applies to all staff. It should be read in conjunction with the Incident Reporting & Management Procedure. This policy has been updated to reflect the Hospice's move from the Serious incident framework (SIF) to the Patient Safety Incident Response Framework (PSIRF).

The key principles include:

- Improvement and learning from patient safety incidents
- Blame restricts insight
- Collaboration is key and curiosity is powerful
- Psychological safety allows learning to occur

PSIRF advocates a coordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards a systems-based approach. 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 issues
- supportive oversight focused on strengthening response system functioning and improvement.

The Hospice advocates a fair and just system where staff are held to account for their actions and behaviors, without being unduly blamed. Every effort will be made to ensure that reported incidents are managed and investigated positively as a way of improving safety through learning.

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

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). This involves working 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. Patients, families, and patient representatives often provide a unique, or different perspective to the circumstances around patient safety incidents and may have questions or needs to that of the organisation that will need to be incorporated into the investigation ensuring that the process is patient centred throughout.

This policy recognises the need to involve patients, families, and patient representatives as soon as possible in all stages of any investigation, or improvement planning, unless they express a wish not to be involved. Please also refer to the Hospice Duty of Candour Policy.

## 3 Involving Colleagues and Partner Agencies.

Involvement of colleagues and partner agencies at the earliest opportunity and throughout an investigation is fundamental when responding to a patient safety incident ensuring that there is a process of openness and transparency throughout. The Hospice will, in accordance with the Fair and Just Culture, continue to promote, support, and encourage incident reporting, including near misses and all levels of harm. Staff and colleagues need to feel supported to speak out and openly report incidents and concerns. They also need to be supported when they are involved in incidents.

## 4 Definitions

**Patient safety incident response framework (PSIRF)** national initiative designed to further improve safety through learning from patient safety incidents. The PSIRF outlines how providers should respond to patient safety incidents, and how and when an investigation should be carried out. It includes the requirement for the publication of a local Patient Safety Incident Response Plan (PSIRP).

**Incident:** any event or circumstance arising that could have, or did, lead to unintended or unexpected harm, loss or damage to a person, property, or the organisation. An incident can cover a wide range of situations but generally a reportable incident is an event that contains one or more of the following components:

- Harm to an individual
- Financial loss to an individual or the Hospice
- Damage to the property of an individual or the Hospice
- Disruption to services provided by the Hospice
- Damage to the reputation of the Hospice

**Harm:** Injury (physical or psychological), disease, suffering, disability, or death.

**Near miss:** Any event or circumstance that did not result in harm, loss or damage, but had the potential to do so.

Please refer to the Patient Safety Incident Response Plan for further definitions

## 5 Responsibilities

**Chief Executive and Director of Patient Services**

The overall responsibility for effective risk management in the Hospice, including incident reporting and management lies with the Chief Executive. At an operational level, the Director of Patient Services is the Director designated with responsibility for governance and risk management.

The Director of Patient Services' key responsibilities in respect of incident reporting and management are:

- Notifying the Trustees Board of incidents reported as Never Events
- Notifying the Board of Directors of incidents considered as meeting the criterion of a PSII
- Presenting reports to the patient service committee of any Patient Safety Incidents Investigations identifying issues of concern, outcome and learning and assurance.

**Managers**

All managers are responsible for:

- Ensuring that all incidents that occur in their area of responsibility are reported in a timely manner and in accordance with Hospice Policies and Procedures.
- Receiving all Sentinel, the electronic reporting system, reports occurring in their area(s) of responsibility and ensuring that immediate action has been taken to manage the incident.
- Identifying causes of incidents and putting in place measures to minimise the likelihood of recurrence by establishing any lessons to be learnt and implementing these locally.
- To review investigation of incidents reported for their area(s) of responsibility.
- Informing their staff of any lessons to be shared both Hospice wide and in the wider health community.
- Escalating any significant concerns to their Clinical lead/Matron/head of department/Director.

- Ensuring that staff are adequately supported following an incident and as required during an investigation
- Liaising with the Human resources department regarding any precautionary measure, capability or disciplinary action proposed regarding a member of their staff following an incident. Senior member of staff on duty when a serious incident occurs in a hospital setting.

**All Staff**

Staff responsibilities include:

- Reporting incidents and near misses promptly. Staff working in the Hospice on a locum or agency basis, or as a contractor or volunteer must also report incidents. Where a member of the public has been involved in an incident, staff must complete an incident form on their behalf.
- If a witness to or directly involved in an incident, addressing the immediate health needs of the person(s) involved in an incident, ensuring that the situation is made safe, informing their manager, and completing an incident on Sentinel.
- Undertaking immediate action to manage the incident and identifying actions needed to minimise the chances of recurrence.
- Engaging in the investigation of incidents and providing information if and when required

## 6 Patient Safety Incident Response Plan (PSIRP)

PSIRF supports organisations to respond to incidents and safety issues 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.

The PSIRP will be:

1. Updated as required and in accordance with emerging intelligence and improvement efforts
2. Published on the Hospice external facing website

The 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.

## 7 Safety Actions Plan/Safety Improvement Plan and Monitoring

PSIRF moves away from the identification of 'recommendations' which may lead to determining a resolution at an early stage of the safety action development process.

**"**Learning response methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. A thorough human factors analysis of a patient safety incident does not always translate into better safety actions to reduce risk. You must move from identifying the learning to implementation of the lessons. Without an integrated process for designing, implementing, and monitoring safety actions, attempts to reduce risk and potential for harm will be limited."

The learning response review and learning tool - see link - https://www.hssib.org.uk/education/learning-response-review-and-improvement-tool/ can be used as a tool for those writing learning response reports following a patient safety incident or complaint and identifies 'traps to avoid' in safety investigations and report writing.

Quality Improvement to support embedded learning and improvement following a patient safety investigation is key to improving patient safety outcomes. Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Where an incident occurs and contributory factors are not well understood, a safety action plan will be drawn up. Where a subsequent incident occurs, the safety actions for this will be compared with the previous incident's safety action plan and will inform an overarching safety improvement plan.

Monitoring of completion and effectiveness of safety actions will be through the Quality Improvement and Clinical Audit group and/or the Learning and Response Group. This will then feed up to the Patient Services Committee.

## 8 External Reporting and Informing Key Stakeholders

Depending on the type of incident, it may require reporting to an external agency or key stakeholder, for example, the Care Quality Commission, the Health & Safety Executive, NHS Digital or the Information Commissioner. PP105b (Incident Reporting and Management Procedure) lists the different external agencies/ stakeholders and the types of incidents they need to be notified of.

## 9 Incident Reporting and Management Training

All staff new to the Hospice will receive mandatory Health & Safety Training as part of their induction which covers how to report incidents. Staff are also required to undertake three yearly updates.

Specialist training for staff undertaking specialist incident investigations as required under PSIRF and will be provided as part of the Hospice training programmes.

Team leaders/Clinical leads/Matron/ANP/ Director of Patient Services/Medical Director/Consultant are to complete the Patient Safety Syllabus Training Level 1 and 2 on the elearning for health website. All clinical staff will undertake level 1 of the Patient Safety Syllabus training and relevant trustees of the Board will attend level 1 of this syllabus which is specifically relevant for them.