

Patient Safety Incident Response Policy

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| **Purpose:**  | This policy sets out Severn Hospice’s approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. |
| **Document Author:** | Director of CarePatient Safety Lead/Matron Clinical Services |
| **Subject Matter Expert/s** | Chief ExecutiveDirector of CarePatient Safety Lead/Matron Clinical Services |
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| **Approved by:** | Clinical Governance Committee |
| **Date First Approved:** |  |
| **Next Review Date:** |  |
| **Related Hospice Policies, SOPs, or Guidelines**  | Health and Safety PolicyComplaints Policy and ProcedureDuty of Candour PolicyRisk Management PolicyIncident Reporting PolicyFreedom to Speak Policy |
| **Relevant External Standards/ Legislation**  | See Reference List |
| **Target Audience:**  | All staff and volunteers of Severn Hospice. |
| **Equality Impact Assessment Completed**  | Yes |
| **Further information:**  | Director of carePatient Safety Lead/Matron Clinical Services |

Fields marked \* only need to be completed for policies.

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**Version History:**

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| 1 | Director of CarePatient Safety Lead/Matron Clinical Services | Clinical Governance Committee |  |
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**Summary of changes from last version: New Policy**

**Table of Contents**

**Section Page**

|  |  |  |
| --- | --- | --- |
| 1 | Introduction/Purpose | **4** |
| 2 | Scope | 4 |
| 3 | Patient Safety Culture | **5** |
| 4 | Addressing Health Inequalities | 6 |
| 5 | Engaging and Involving Patients, Families and Staff following a patient safety incident. | 6 |
| 6 | Patient safety incident response planning | 6 |
| 7 | Our patient safety incident response plan | 7 |
| 8 | Reviewing our patient safety incident response policy and plan | 7 |
| 9 | Responding to patient safety incidents | 7 |
| 10 | Roles and Responsibilities | 9 |
| 11 | References | 10 |
| 12 | Equality Impact Assessment Screening Tool | 11 |

# **Introduction / Purpose**

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Severn 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. The policy has been developed using the national template.

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 issues
* supportive oversight focused on strengthening response system functioning and improvement.

# **Scope**

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement acrossSevern hospice sites**.** Related documents include:

* Incident reporting and Investigation Policy 2023
* Duty of Candour Policy 2022
* Information Governance Policy 2023
* Complaints Policy 2022
* Medicines Policy 2022
* Non-medical prescribing policy 2022
* Pressure area management policy 2023
* Raising a concern (Freedom to Speak up) Policy 2022
* Risk Management Strategy 2023
* Safeguarding Adults Policy 2022
* Safeguarding Children and young people Policy 2021
* Suicide policy 2022
* Slips, trips and falls policy 2022
* Health and safety policy 2023

<https://severnhospicelimited.sharepoint.com/Policies>

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between ‘patient safety incidents’ and ‘Serious Incidents’. As such it removes the ‘Serious Incidents’ classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF is not a different way of describing what came before – it fundamentally shifts how Severn Hospice responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. Instead, it:

* advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents.
* embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This system-based approach recognises that healthcare takes place in a work system composed of people, tasks, equipment, and different environments. All these aspects of the system vary and interact with each other to produce different outcomes. By exploring how these different aspects are working together in different situations, a deeper understanding of the risks and issues facing patients and staff can be gathered, and more effective learning can be identified. The Systems Engineering Initiative for Patient Safety (SEIPS) will be used to support learning from patient safety events and to support responding to broad patient safety issues. [Several systems based tools.](https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/)

1. **Patient safety culture**

Severn Hospice supports a just Culture, ensuring consistent, constructive, and fair treatment of staff who have been involved in patient safety incidents e.g., the staff survey asks about whether staff feel safe to speak up about unsafe clinical practice or any concerns about the organisation and believe the Hospice acts on concerns raised by patients or staff; communication and awareness raising through the Safe Culture campaign; incorporating Hospice values in our recruitment and appraisal processes to ensure the key drivers of a just culture of respect, compassion and learning are embedded within our organisation; and relevant patient safety training. While these organisational values support a strong safety culture, the implementation of PSIRF is anticipated to improve this further. The new procedures and forums being implemented as part of PSIRF will support the improvement of our safety culture through engagement, shared learning, supporting improvement and identifying opportunities to spread good practice. [NHS\_0932\_JC\_Guide\_A3 (england.nhs.uk)](https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf)

Current initiatives to provide an opportunity for staff to share concerns about patient or staff safety and to share learning from safety messages or meetings include:

* Patient Safety Lead
* Reflection sessions
* Staff survey
* Staff forum
* Medicines Safety Group
* Champions – tissue viability, infection control, safeguarding.
* Team meetings
* Clinical Supervision
* Appraisal
* Freedom to Speak policy
1. **Addressing health inequalities**

Reducing health inequalities is a key objective running through the Severn Hospice Clinical Strategy. One of our aims is to improve the data to capture health inequalities including ethnicity. This data will support a better understanding of issues related to local health inequalities and provide information that can be used to improve care for these populations. As part of our ‘quality priorities’ our Community Engagement Lead will explore local demographics and barriers associated with low engagement with Hospice care and co-develop strategies to overcome these barriers with local health partners.

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

Severn Hospice 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 response system that prioritises compassionate engagement and involvement of those affected 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.

1. **Patient safety incident response planning**

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. Although there are no additional resources provided to implement PSIRF, there will be a focus on learning, efficiency, and effectiveness.

1. **Our patient safety incident response plan**

Our plan sets out how Severn Hospice 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.

1. **Reviewing our patient safety incident response policy and 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 discuss any themes or trends every quarter through Clinical Governance to inform our initial Patient Safety Profile. This PSIRF policy will be reviewed every 3 years to ensure efforts continue to be balanced between learning and improvement. This review will include reviewing our response capacity, organisational data - for example patient safety incident investigation (PSIIs) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and general reporting data.

1. **Responding to patient safety incidents (SHARE debrief)**

Patient safety incidents are recorded and monitored through the Hospice Datix System, and this will remain the same under PSIRF. The Quality Assurance Framework (Quality Account) in place provides assurance to the Board that there are effective processes in place to monitor, action and improve quality and safety at Severn Hospice. Monitoring of patient safety incidents at a local level, through the delivery unit’s governance meetings will remain the same, supported by their respective Clinical Governance Managers. External processes will continue to include involvement of healthcare partners, our regulators and the public, supporting open and transparent reporting.

Depending on the type of incident a notification will be automatically sent to the relevant people in that division and/or area of expertise. An automatic feedback function is also available for staff who have reported an incident.

Safety actions will be developed within the divisions involved in the area that the incident occurred and be based on the recommendations of the investigators. Action plans will be monitored, key issues will be considered, and learning responses will be escalated / de-escalated as appropriate. Positive change and improvement will be shared.



<https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SHARE-Debrief-v1-FINAL.pdf>

Our Clinical Governance Committee will review learning from key incidents, provide an opportunity for the wider multidisciplinary team and Trustees to contribute to the learning, and add further safety actions, and request additional learning response types, as deemed necessary.

Severn Hospice will help to facilitate any incident that crosses more than one Healthcare organisation. This encourages a more cohesive and effective method of learning from incidents that are cross system. Common partners include private providers, Primary care, ambulance services, ICB patient safety teams. Information governance agreements allow information sharing within and between relevant bodies to support effective communication during both incident response and improvement endeavours.

# **Roles and Responsibilities**

### Chief Executive

The Chief Executive has overall responsibility for the safety of the Trust’s patients, staff, and visitors. The systems and process management responsibilities for the PSIRF are delegated by the Chief Executive as follows:

Director of Care and Medical Director

* overseeing the quality of the PSIRF process which includes the development, implementation, and review of this policy.
* ensuring the processes are in place so that meaningful information about incident reporting and management is presented to and reviewed by the Board.
* ensuring processes are in place for triangulating incident information for early identification of themes and trends.
* ensuring there are adequate mechanisms for learning and feedback of outcomes of incidents.
* overseeing compliance with the duty of candour
* leading the assessment of incidents that fall outside of the local priorities for new and emerging themes.
* ensuring that the Chief Executive (CEO) is kept fully informed about any national priorities.
* aligned to PSIRF reporting the details of the incident to the clinical Governance Committee.
* lead on revising the Trust PSIRP and full PSIRF review as stipulated in the policy.

Patient Safety Lead

* Ensures that the hospice meets national patient safety incident response standards.
* Provides dynamic patient safety leadership.
* Leads the development of a patient safety culture, safety systems and improvement activity.
* Co-ordinate and support Hospice’s patient safety priorities.
* Support learning/training as required.
* In conjunction with the Director of Care, is responsible for reviewing any Patient Safety Incident Investigation (PSII) and signing it off as finalised.

Quality Improvement and Education Lead

* Advise the Director of Care / Medical Director / Patient safety lead on a proportionate response method in relation to patient safety.
* Liaising with external bodies in relation to national priorities as required.
* Support learning where required but in particular where a full investigation is needed.
* Monitor completion of organisational safety improvement actions.
* Evaluation learning responses and effectiveness of safety actions.
* Provide training on PSIRF as required.

All Managers

* Escalating matters of concern to relevant managers
* Responsible for ensuring staff can access support following a patient safety event, should this be required, including giving the employee details of supporting services.
* Required to support the release of staff to provide statements or attend interviews or meetings relating to the patient safety event.
* Expected to complete Level 1 & Level 2 of the patient safety training syllabus.

All Staff

* Have a responsibility to report via Datix all incidents and near misses, both patient safety and non-patient safety.
* Required to co-operate with learning responses and provide any requested information, including statements and attend interviews when required.
* Expected to complete Level 1 of the Patient Safety training.

# **7. References**

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| --- | --- | --- |
| **Date**  | **Title**  | **Publisher**  |
| August 2022 | Patient Safety Incident Response Standards | NHS England |
| 2021 | Patient safety Strategy | NHS England |
| 2022 | SHARE debrief tool | NHS England |
| 2020 | Patient Safety Incident Response Framework (PSIRF) | NHS England/NHS Improvement |
| August 2020 | Patient Safety Incident Response Framework (PSIRF)Oversight roles and responsibilities specification | NHS England/NHS Improvement |
| August 2020 | Patient safety incident response plan | NHS England/NHS Improvement |
| May2023 | The National Policy on Patient Safety Incident Reporting | NHS Wales |
| 2018 | Confidentiality and Data protection Act | Legislation.gov.uk |
| 2014 | The care Act | Gov.uk |

**8. Equality Impact Assessment Screening Tool**

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| **Title of policy or service:** | Patient Safety Incident Response Policy |
| **Name and role of person completing the assessment:** |  |
| **Date of assessment:** |  |
| **Type of EIA completed:**   |  |

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| **1. Outline** |
| **Give a summary of your policy or service** | . |
| **What outcomes do you want to achieve** |  |
| **Give details of evidence, data or research used to inform the analysis of impact** |  |
| **Give details of all consultation and engagement activities used to inform the analysis of impact** |  |

**Identifying impact:**

* **Positive Impact:** will actively promote the standards and values of Severn Hospice.
* **Neutral Impact:** where there are no notable consequences for any group.
* **Negative Impact:** negative or adverse impact causes or fails to mitigate unacceptable behaviour. If such an impact is identified, the EIA should ensure, that as far as possible, it is eliminated, minimised, or counterbalanced by other measures. This may result in a ‘full’ EIA process.

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| **2. Gathering of Information** This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.  |
|  | **Impact Identified**  | **For impact identified (either positive or negative) give details below:**  |
| **Positive Impact**  | **Neutral impact** | **Negative impact** | **How does this impact and what action, if any, do you need to take to address these issues?** | **What difference will this make?** |
| **Age** |  |  |  |  |  |
| **Disability (please consider disability such as physical, hearing, visual impairment, mental health etc.)** |  |  |  |  |  |
| **Sex** |  |  |  |  |  |
| **Ethnic origin and race**  |  |  |  |  |  |
| **Visitors and Carers** |  |  |  |  |  |
| **Religion or belief** |  |  |  |  |  |
| **Sexual orientation** |  |  |  |  |  |
| **Gender reassignment** |  |  |  |  |  |
| **Pregnancy and maternity** |  |  |  |  |  |
| **Marriage and civil partnership** (only eliminating discrimination) |  |  |  |  |  |

**Appendix 1**