What is Patient Safety Incident Response Framework (PSIRF)?

The four key aims of PSIRF are:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

We analysed our current systems to enhance our understanding of patient safety processes, and this allowed us to use these insights to develop our Patient Safety Incident Response Plan (PSIRF).

Patient Safety Incident Response Plan

1. Introduction

In 2019, the NHS Patient Safety Strategy was published. This introduced the Patient Safety Incident Response Framework (PSIRF), a framework that would challenge us to think and respond differently when a patient safety incident occurs and replacing the previous NHS Serious Incident Framework. This document outlines how St Catherine's Hospice (SCH) will respond to patient safety incidents.

PSIRF is designed to promote learning and systemic improvement, moving away from the previous serious incident response framework that focused more on process rather than on fostering a culture of continuous improvement in patient safety.

This framework emphasises conducting investigations collaboratively, led by trained individuals. It ensures the involvement of patients, their carer's, families, and staff in a system that responds appropriately to the type of incidents and associated factors. It recognises the need to provide a safe and supportive environment for those involved in any investigation, with a focus on systemic improvement.

2. Our Services

At St Catherine's Hospice (SCH) we care for patients and families across Chorley, Preston and South Ribble who are affected by life-shortening conditions like cancer, motor neurone disease and heart failure.

Our specialised care is here to help people enjoy the best possible quality of life, to the end of life. We work with patients and their loved ones at the hospice and in their own homes to help them achieve what is important to them in the time they have.

We run a 19 bedded Unit and our multi-disciplinary team cares for people with complex palliative care needs.

Our services include:

- Our community nursing team are registered clinical nurse specialist (CNS) who have specialist training and experience in palliative care.

- Our Hospice at Home team, registered nurses and health care assistants are here to help people and loved ones in times of fear, pain or distress.

- Our Lymphoedema team treats cancer and non-cancer related lymphoedema – a condition which affects our lymphatic system, the process by which we filter and drain waste fluid from our bodies.

- Our specialist nurses offer treatments to ease discomfort, improve quality of life and enhance your independence, by helping you to understand and cope with your condition, and advising you how to take care of yourself through techniques such as exercises, massage, and skincare routines.

- We have an amazing team of volunteers helping out on our reception desk, supporting the IPU, volunteering at a fundraising event, working in our shops or at The Mill Café, and

- We also work creatively and collaboratively with other organisations, businesses, charities and local people to meet the needs of our patients and their loved ones.

3. Reaching More People

Our values are caring, compassionate and committed.

4. Defining our patient safety incident profile

When things go wrong, patients are at risk of harm, and many others may be affected. For the staff involved, incidents can be distressing, and members of the clinical teams can become demoralised and disengaged. Often, these incidents are caused by system design issues, not by individual mistakes alone.

This patient safety incident response plan (PSIRF) details how SCH will seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care we provide.

5. Our individual safety event response plan: local focus

The aim of our PSIRF policy and plan is to provide guidance and clarity as to how we intend to embed the new framework and respond compassionately to patient safety incidents.

To determine any priority areas to support the delivery of the new PSIRF, an understanding of the scale of patient related safety activity was required.

We used a thematic analysis approach to determine which areas of patient safety activity we would focus on to identify our patient safety priorities with data extracted from our Incident Management Tool, Vantage which was introduced in 2022 to help us improve our management of patient care.

We will continue to use the Vantage Incident Management Tool as the recording method for the 'After Action Review' (AAR). This will ensure:

- An event is captured and recorded
- The intended outcome versus the actual outcome of that event is analysed, whether positive or negative
- The improvement of processes from any learnings.

At SCH we reported a high number of low-level patient safety incidents through our internal processes which we always seek learning from to minimise any concerns relating to patient safety, including near misses.

Our key areas of focus and proposed action to take, where applicable therefore are captured within the table below.

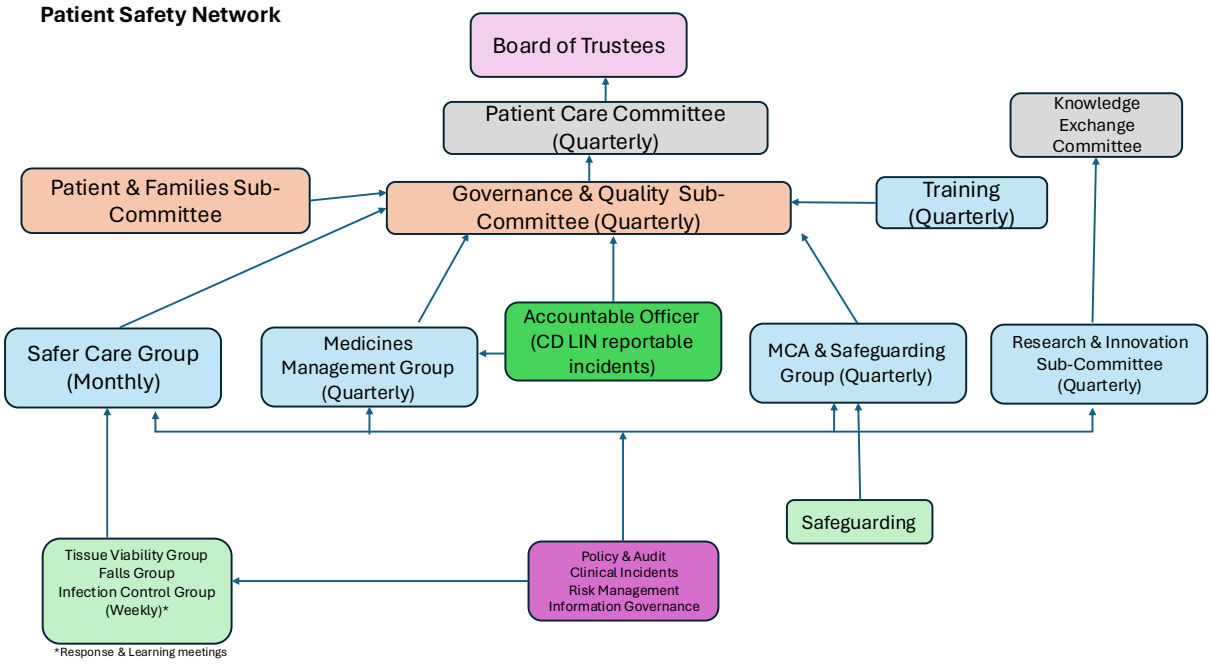
INCIDENT	Review / Action Undertaken	REPORT TO:	
		INTERNAL	EXTERNAL
Falls	MORSE / AAR or **if Severe** Thematic Review / Patient Safety Investigation (PSII) Report	1.Falls Group 2.Safer Care Group. 3.Governance & Quality Committee. 4.Patient Care Committee.	Care Quality Commission (CQC)* NHS Lancashire and Cumbria Integrated Care Board (patient safety incidents (Severe or Death) only)
Medications	AAR If severe: Thematic Review / PSII Report	1.Medicines Management Committee. 2.Governance & Quality Committee. 3.Patient Care Committee.	CD LIN & NHS Lancashire and Cumbria Integrated Care Board (patient safety incidents (Severe or Death) only)
Pressure Ulcers	AAR If G3 or > and inherited: Thematic Review / PSII Report	1.Tissue Viability Group 2.Safer Care Group 3.Governance & Quality Committee. 4.Patient Care Committee.	CQC* Safeguarding referral. PiPoT
Never Events e.g. NG Tube	Thematic Review / PSII Report Never Events Report	1.Patient Care Group.	NHS England

All incidents involving controlled drugs should be reported to SCH's Accountable Officer when they occur. Reviews may lead to the need to undertake a Thematic Review or a Multidisciplinary (MDT) Review.

6. Governance

The following groups have been established to support PSIRF. These groups will also provide assurance that learning (recorded in our Monthly & Weekly Assurance Frameworks), and quality improvement changes have been embedded in identified cases.

Our patient safety network will feed into our overall Governance and Management framework already embedded at the hospice.



All patient safety incidents can be escalated to a higher level at any time where required; for example, if initial fact finding highlights further concern, this can be escalated for a formal investigation.

Any incidents that meet the criteria for a patient safety incident investigation (PSII) will be identified by the patient safety team and the appropriate people determined to investigate and manage them.

Any incident that has been categorised as moderate harm or above will have a PSII completed using System Engineering Initiative for Patient Safety (SEIPS) thinking. Once the PSII has been completed.

All incidents are investigated monitored & reported as noted above and all incidents will continue to be reported to relevant regulators including the CQC, as required.

7. Supporting families and staff

Families and staff will be signposted for support during engagement or involvement in a learning response. Sources of support for families will include the hospice Support Services, together with bereavement and counselling services. In addition to the above, staff can also access support from their manager, the Employee Assistance Programme, and the hospice's occupational health service.

Oversight around families sits within the quarterly patient and families sub-committee.

8. Working with system partners

The hospice will actively engage partner organisations that provided care to the individual(s) involved where that care may have played a role in the event being examined e.g., District Nursing Services, GPs, acute sector. We will work together and co-operate with any learning response that crosses organisational boundaries

9. Our Patient Safety & Experience Response Plan: National Requirements

Under our PSIRF Plan and Policy, it is a requirement that we will continue to undertake full investigations in relation to national requirements. The following table outlines how we are expected to respond to our nationally defined priorities.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria 2018	PSII led by SCH	Create local hospice actions and feed these into the governance & quality improvement strategy.
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 led by the provider. Where the event did not occur at SCH but there was involvement - SCH will participate with the investigation, as required.	Create local hospice actions and feed these into the governance & quality improvement strategy.
Safeguarding events in which:	Refer to the Local Authority Safeguarding lead.	Respond to recommendations from external referred agency/

Adults (over 18 years old) are in receipt of care and support needs by their Local Authority	SCH safeguarding lead will contribute towards any safeguarding event as required to do so by the Local Safeguarding Partnership (for children) and the Local Safeguarding Adults Board.	organisation as required. Feed actions into governance & quality improvement strategy.

We acknowledge that there are other reporting requirements, for example, reporting to the Accountable Officer, Care Quality Commission and the Charity Commission, and these processes will continue in line with our registration requirements.

10. Review of the plan

This PSIRF plan is a live document that outlines how SCH intends to respond to patient safety incidents over a 12 month period. The plan will be continuously reviewed to ensure potential future categories for local patient safety incident investigation and system improvement are included as required with a 12 month initial review and every 36 months thereafter in line with our PSIRF Policy.

The Policy and Plan will be published on our internal intranet and will be made available on request.

11. Stakeholder Engagement

The SCH Executive Team and Trustees have been kept informed of the development and implementation of PSIRF and this plan. Both this plan and the supporting policy will be sent to the Lancashire & South Cumbria ICB for final sign off.

12. Training

All staff will receive training in accordance with national requirements. Education planning and allocation will happen between July 2024 and June 2025. At SCH we have used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

NHS Patient Safety Syllabus training - elearning for healthcare

Training available for staff to support PSIRF

	Level 1 Essentials of patient safety for all staff, clinical staff, learning response leads (at induction and 3 yearly thereafter)	Patient Safety in the management and administrative sector	Level One – Essentials for Patient Safety for Boards and senior leadership teams – executive lead & Trustee	Level 2: Access to Practice 1 and Access to Practice 2
All Staff	✓			
All clinical staff	✓	✓ (Clinical Management, HR & Finance)		
PSIRF Director	✓		✓	✓
Deputy PSIRF Director	✓		✓	✓
PSIRF Lead	✓			
PSIRF Deputy Lead	✓			
PSIRF Trustee			✓	

Records of such training will be maintained by the Knowledge Exchange team as part of their general education governance processes.

13. Action required to embed PSIRF into SCH

- Provide appropriate training to all clinical staff as per s12 above
- Capacity for the members of the new weekly response and learning meetings to work effectively to ensure the terms of reference are being met
- Identify people to act as patient liaison support for PSII and ensure they are appropriately skilled and trained
- To proactively promote a positive culture of safety based on openness and honesty.
- Develop a leaflet for patients that explains the PSII cycle.

14. References

NHS England patient safety learning response toolkit NHS England » Patient safety learning response toolkit

NHS England » Patient Safety Incident Response Framework

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations - HSE

15. Conclusion

SCH recognise and agree that adopting the NHS Patient Safety Incident Response Framework Plan represents a crucial step forward in our ongoing commitment to patient safety and ensuring the well-being of patients within the hospice, and also the wider healthcare system in Chorley, Preston and South Ribble. By establishing a comprehensive framework that prioritises the identification, reporting, and learning from safety incidents, our plan demonstrates our dedication to continuous improvement and the delivery of high-quality, safe healthcare services.