



THE PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) POLICY	
Document purpose	The purpose of this framework document is to give staff clear direction and purpose as to how children are to be kept safe in the hospice's care and that no preventable harm occurs.
Author	Clinical Quality and Compliance Lead
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Main Headings	<ol style="list-style-type: none"> 1. Purpose 2. Scope 3. Related Documents 4. Patient Safety Culture 5. Engaging and involving patients, families and staff following a patient safety incident 6. Patient safety incident response planning 7. Resources to support patient safety incident responses 8. Staff Training Requirements 9. Patient safety incident report plan 10. Addressing health inequalities 11. Policy Monitoring and Review
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Signed

Date

Mark Stowe

Interim Chief Executive Officer

1. PURPOSE

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

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds the patient safety incident response within a wider system of quality improvement and prompts a 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 concerns
- Supportive oversight focused on strengthening the response system functioning and improvement

2. SCOPE

This document is specific to patient safety incident responses conducted solely for the purpose of learning and improvement, this includes cross system collaboration and learning where more than one provider is involved. Responses under this policy follow a system-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.

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. Investigations will follow a Just and restorative approach.

Proportionate response to incident

Reflecting on the many ways in which healthcare can fail or harm patients, it is clear a range of approaches to patient safety are required to reduce risks and provide the highest standard of care. Responses covered in this plan include:

**Please note: Criteria on Never events are unchanged and remain in line with legislation NHS England Never events policy and framework [Revised-Never-Events-policy-and-framework-FINAL.pdf](#)*

- Patient Safety Incident Investigations (PSIIs)
- Multidisciplinary Team meeting (MDT)
- Incident type specific thematic review meeting (i.e. Falls, Tissue viability, Infection prevention and control, medication incidents)
- Hot debrief
- After action review (AAR)

- Thematic review
- System engineering initiative for patient safety (SEIPS) Framework
- Direct observation

Other types of response exist to manage specific issues or concerns. Examples of such responses include complaints management, human resources investigations into employment concerns, professional standards investigations, coroners' inquests, or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this policy.

3. RELATED DOCUMENTS

These documents should be referenced in conjunction with this policy

- Incident policy
- Clinical Complaints Policy
- Medicines management policies and procedures
- Duty of candour policy
- Safeguarding policy statement and framework
- Disciplinary Policy
- Information Governance Policy

4. PATIENT SAFETY CULTURE

Helen & Douglas House promotes a just culture approach, in line with the NHS Just Culture Guide. There is a robust, transparent and reflective incident reporting system using Datix to record incidents, investigations and action plans. We have a workforce who are encouraged to reflect on learning from incidents to support development. Learning outcomes are discussed and shared with staff. PSIRF will enhance this approach by creating much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame or liability. We support both the psychological and physical safety of staff by providing a range of clinical supervision sessions, 1:1's, appraisals, reflective practice sessions and wellbeing initiatives.

To enhance our patient safety culture, all incidents are discussed weekly by the Safety Huddle senior team with executive oversight where we consider recent incidents, response required, known and emerging risks and the insight offered from incidents that have occurred and an opportunity to share learning.

We will utilise findings from our staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture.

Helen & Douglas House aims to ensure everyone working within the hospice feels safe and confident to speak up. We encourage our senior leadership team and trustees to listen and take

the opportunity to learn and improve from those who speak up. All staff are encouraged to speak up about anything that affects the safe care of patients or their working life. Staff can contact their line manager in the first instance.

Helen & Douglas House has Freedom to Speak up Guardians, who can support staff speaking up if they feel unable to do so by other routes. Further information and contact details can be found on our Intranet: The Hive.

Engagement of patient, families and staff following a patient safety incident is critical to review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

Equality, Diversity and Inclusion (EDI) remain a clear priority for the hospice and through this we endorse a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families.

5. 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 system 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.

Helen & Douglas House are committed to continuous quality improvement of the care and services we provide. We recognise and acknowledge the significant impact on patients, their families, and carers where care does not go as planned or expected. Involving patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide and preventing reoccurrence. Part of this involves our key principle of being open and honest whenever there is a concern about care not being delivered as planned or expected or when a mistake has been made. In addition to meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident.

If families do not wish to be contacted directly to discuss a patient safety incident, an intermediary can be offered and would be decided on a case-by-case basis, including communicating responses to questions those affected may have, updates on the progress of an investigation, and to request checking of the draft report factual accuracy.

The use of professional translator and interpreter services will be provided when necessary, ensuring that information is clearly conveyed and that those involved can actively participate in discussions and decision-making. This approach supports inclusivity, enhances understanding, and upholds our organisational commitment to transparency and equitable care. The use of qualified translators is essential to avoid miscommunication, reduce distress, and ensure that all voices are heard, contributing to a thorough and compassionate incident response.

6. PATIENT SAFETY INCIDENT RESPONSE PLANNING

Beyond nationally set requirements, PSIRF encourages organisations to explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a defined threshold.

Helen & Douglas House will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. We will use data from incidents, patient and colleague feedback and complaints to determine areas of risk and where to focus efforts on improvement work. Our patient safety incident response plan details how this will be achieved and details how we will meet both national and local focus for patient safety incident responses.

7. RESOURCES TO SUPPORT PATIENT SAFETY INCIDENT RESPONSES

Helen & Douglas House has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

The hospice will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

The Head of Professional Development will be the Learning Response Lead. The hospice will have governance arrangements in place to ensure that learning responses are undertaken by an appropriate member of the patient safety team as decided by the senior clinical team.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All managers will work within our just and restorative culture principles and will have processes in place to ensure psychological safety.

8. STAFF TRAINING REQUIREMENTS

All staff are required to undertake mandatory training relating to patient safety that is relevant to their role, attendance at training is recorded and monitored through the organisations Training record system and reported via the Quarterly Quality Report. See PSIRF Plan document for training requirements.

The hospice has implemented a patient safety training package to ensure that all staff and clinical trustees are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows:

- Level one National – Health Education England patient safety syllabus module (Essentials for patient safety) All clinical staff are expected to undertake these on induction and to repeat each three years. These modules can be accessed digitally.
- Level two National – Health Education England patient safety syllabus module (Access to Practice) – this is to be undertaken by all clinical staff. This module is available digitally.

Learning response leads training and competencies

The learning response lead will be the Head of Professional Development, but all senior clinical team members and clinical leads (Band 7 and above) will be expected to be able to lead learning responses. They will have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response. The learning

response lead will undertake appropriate continuous professional development on incident response skills and knowledge.

All patient safety response oversight will be led/conducted by those who have had one day training in oversight of learning from patient safety incidents. Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

Trauma Informed Care

Staff can access support through clinical supervision, 1:1's, debriefs and have access to the Employee Assistance Programme (EAP).

Helen & Douglas House recognises the importance of embedding trauma-informed care within the Patient Safety Incident Response Framework (PSIRF) to support patients, families, and staff affected by adverse events. Trauma-informed care focuses on understanding, recognising, and responding to the impact of trauma, creating a culture of safety, empowerment, and healing. In line with the PSIRF principles of compassionate engagement, a trauma-informed approach ensures that individuals' psychological and emotional needs are prioritised during incident response processes. This reduces the risk of re-traumatisation, fosters open communication, and builds trust in the organisation's commitment to transparency, learning, and improvement. By integrating trauma-informed principles into PSIRF, we aim to provide holistic support and strengthen the resilience of all those involved in patient safety events.

TRiM stands for **Trauma Risk Management**. It is a peer-support system designed to identify and support individuals at risk of developing mental health issues, such as PTSD (Post-Traumatic Stress Disorder), following exposure to traumatic events. Below are descriptions of the TRiM Practitioner and TRiM Manager roles.

A TRiM Practitioner is trained to provide initial trauma support and conduct structured risk assessments for colleagues who have been exposed to potentially traumatic incidents. Their role focuses on early intervention and peer-based support.

Key Responsibilities:

1. Initial Contact and Assessment

- a. Engage with individuals who have experienced trauma to assess their mental health risks.
- b. Conduct trauma-focused risk assessments using structured tools.

2. Peer Support

- a. Provide a safe, supportive environment for colleagues to talk.
- b. Normalize emotional responses and reduce stigma surrounding trauma.

3. Monitoring and Signposting

- a. Monitor individuals over time to assess for emerging or escalating issues.
- b. Refer individuals to professional support services (e.g., mental health services) if required.

4. Documentation and Confidentiality

- a. Record assessments and outcomes sensitively and securely.
- b. Maintain confidentiality unless there is a risk of harm to the individual or others.

5. Education and Awareness

- a. Promote awareness of trauma and stress reactions among teams.

A TRiM Manager has additional responsibilities beyond those of a TRiM Practitioner. They oversee the implementation of the TRiM program, ensure its effectiveness, and support the team of TRiM Practitioners.

Key Responsibilities:

1. Oversight and Leadership

- a. Coordinate and manage the TRiM process within an organisation.
- b. Provide leadership and support for TRiM Practitioners.

2. Case Reviews and Supervision

- a. Oversee and review individual cases handled by TRiM Practitioners.
- b. Ensure consistency and quality of trauma risk assessments.

3. Training and Development

- a. Facilitate or organize TRiM Practitioner training programs.
- b. Ensure TRiM Practitioners are confident and up to date with processes.

9. PATIENT SAFETY INCIDENT REPORT PLAN

Our plan sets out how Helen & Douglas House intends to respond to patient safety incidents over a period of 12 months. The plan will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected.

Our patient safety incident response plan will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan initially after 12 months and then every 24 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 to discuss and agree any changes made in the previous 24 months.

Responding to patient safety incidents

All staff are responsible for reporting any potential or actual patient safety incident via our electronic internal reporting system (Datix). Any complaint or feedback received by patients will be recorded on Datix to allow for thematic analysis. All reported patient safety incidents will be flagged to the group of people predefined in Datix as needing sight of that incident type. The system is designed to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to teams where Duty of Candour applies. Most incidents will only require local review, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be collaboration with other stake holders.

The senior clinical team have delegated responsibility for the consideration of incidents for PSII and for oversight of the outcomes of such reviews to ensure that recommendations are founded on a system-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

Oversight roles and responsibilities

Helen & Douglas House has designated the Director of Nursing and Care to support PSIRF as the executive lead. The executive lead will oversee the development, review and approval of the hospice's policy and plan ensuring the expectations set out in the patient safety incident

response standards are met via delegation of duties. The policy and plan will promote the restorative just working culture that the hospice aspires to.

All staff will be responsible for the reporting of incidents with detail as needed and playing a part in initial investigations into those incidents to ascertain what has happened and allow the patient safety group to make an informed decision about what response is proportionate. All staff are responsible for selecting the correct incident types on Datix in order that appropriate people are informed.

Timescales for patient safety PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of the start date. No local PSII should take longer than six months.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the hospice and those affected.

10. ADDRESSING HEALTH INEQUALITIES

We recognise that we have a core role to play in reducing inequalities by improving access to palliative care services and tailoring those services around the needs of the local population in an inclusive way.

We will collect data on protected characteristics and use this intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. As part of our new incident response framework, protected characteristics will be considered as part of the patient safety review to give insight into any apparent inequalities.

Within our patient safety responses using the NHS Patient safety learning response toolkit we will directly address if there are any features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics.

Engagement of patient, families and staff following a patient safety incident is critical to review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

Equality, Diversity and Inclusion (EDI) remain a clear priority for the hospice and through this we endorse a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families.

11. POLICY MONITORING AND REVIEW

This document shall be reviewed annually as a minimum, or sooner in response to changes in legislation or practice. Adherence to this document shall be monitored quarterly through Quarterly Clinical Governance meetings.

The Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Clinical Governance Committee. The quarterly quality report will include all incident data as well as specific outcomes and learning from any PSII.

The local safety themes identified will be reviewed on a quarterly basis to ensure no new emerging themes.



THE PATIENT SAFETY INCIDENT RESPONSE PLAN (PSIRP)
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Document purpose	The purpose of this framework document is to give staff clear direction and purpose as to how children are to be kept safe in the hospice's care and that no preventable harm occurs.
Author	Clinical Quality and Compliance Lead
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Main Headings	<ol style="list-style-type: none"> 1. Introduction 2. Our services 3. Patient safety governance structure 4. Patient safety profile 5. Quality Improvement work 6. Training 7. Our patient safety incident response plan: national requirements 8. Our patient safety incident response plan: local focus 9. Response linked with Quality Improvement Projects locally 10. Tools for patient safety review of incidents/Glossary of terms 11. Supporting Documents
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1. INTRODUCTION

This patient safety incident response plan (PSIRP) sets out how Helen & Douglas House intends to respond to patient safety incidents over a period of 12 months, starting from March 2025. The plan is flexible and will be reviewed in response to its effectiveness. We will consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. 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 to which they belong can become demoralised and disengaged. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals. This patient safety incident response plan (PSIRP) details how Helen & Douglas House will seek to learn from patient safety incidents reported by staff, volunteers, families, patients and carers as part of our work to continually improve the quality and safety of the care we provide. This plan will help us measurably improve the efficacy of our local patient safety incident investigations through:

- a) rigorous identification of interconnected causal factors and systems issues
- b) focusing on addressing these causal factors and the use of quality improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents
- c) transferring the emphasis from the quantity to the quality of investigations such that it increases our stakeholders' (notably patients, families, volunteers, carers and staff) confidence in the improvement of patient safety through learning from incidents
- d) demonstrating the added value from the above approach. The Patient Safety Incident Response Framework (PSIRF) recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. This plan provides the headlines and description of how PSIRF will be applied at Helen & Douglas House.

2. OUR SERVICES

Helen & Douglas House is a registered charity providing palliative care for children and young people up until their 19th birthday. Our services cover the Thames Valley area, which includes Oxfordshire and the surrounding areas. We work closely with health and social care professionals, striving for 'every life a full life, every death a dignified death'. We also extend our support to families and carers throughout the child's life, through death and bereavement. Children, young people and their families have access to a wide range of opportunities at Helen & Douglas House. We provide a breadth of professional health and social care support including specialist palliative care, a wide skill mix of doctors, nurses, care support workers, social workers, physiotherapist, teacher, sibling support and bereavement support workers. We are committed to caring for, and supporting children and young people through their shortened life, by offering the following services:

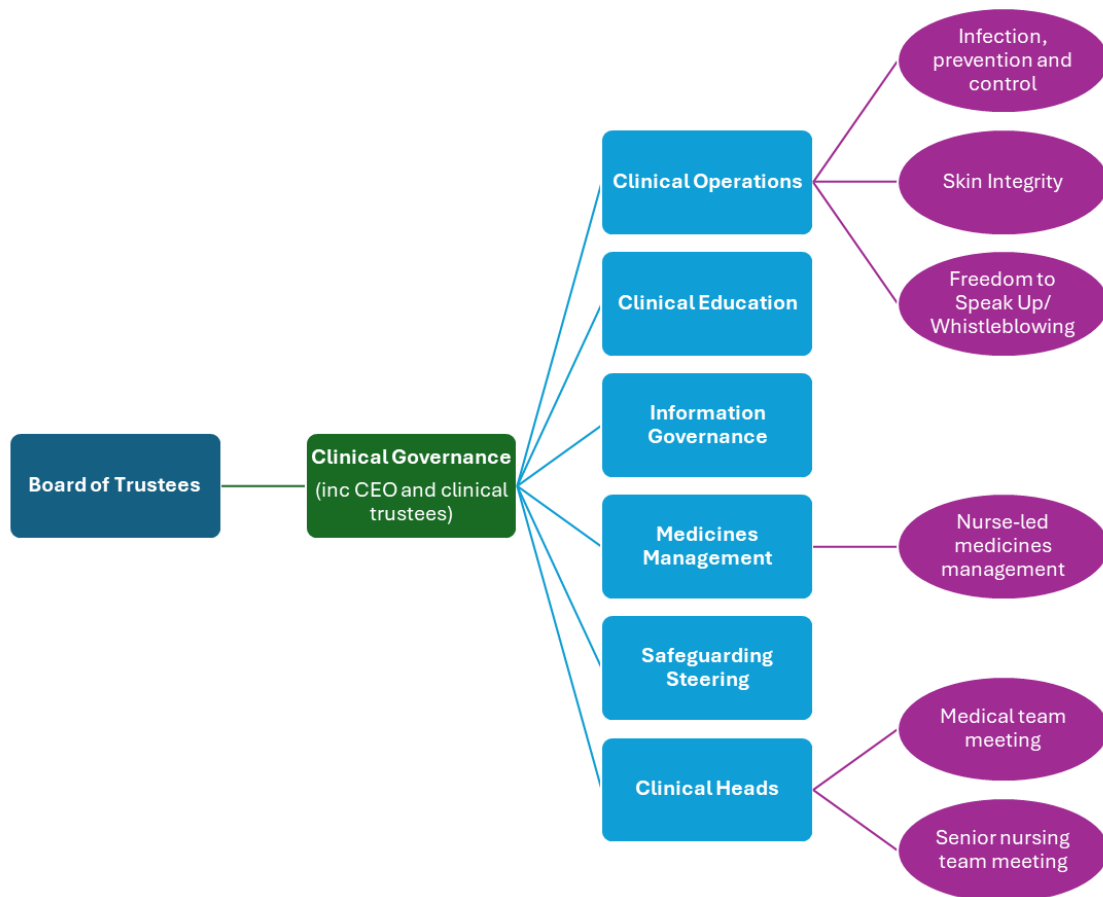
- Supportive stays
- Symptom management
- Outreach in the community
- Community and family support services
- Youth and transition into adult services
- End of life care
- Care post death

Our strategic priorities and how they are linked to formulate our PSIRF aims:

Strategic improvement	PSIRF aims
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Removing barriers to equitable access	Addressing safety inequities; Equity-focused outreach identifies risks for underserved families, preventing avoidable harm.
Embedding FREDIE principles (Fairness, Respect, Equality, Diversity, Inclusion and Engagement)	Fostering a just culture; Encouraging open communication among staff supports PSIRF's goal of reducing fear of reporting incidents.
Expanding digital capabilities	Data-driven improvement; Digital tools for incident tracking align with PSIRF's emphasis on robust data analysis.
Enhancing bereavement support	Holistic safety response; PSIRF's focus on holistic patient and family care is reflected in expanded support for grieving families
Developing partnerships with faith-based groups	Inclusive care models; Collaborative partnerships address cultural safety and enhance family trust in care.

3. PATIENT SAFETY GOVERNANCE STRUCTURE



Helen & Douglas House has identified the following key patient safety leads

- **PSIRF Executive Lead** – Director of Nursing and Care
- **PSIRF Learning Response Lead** – Heads of Professional Development

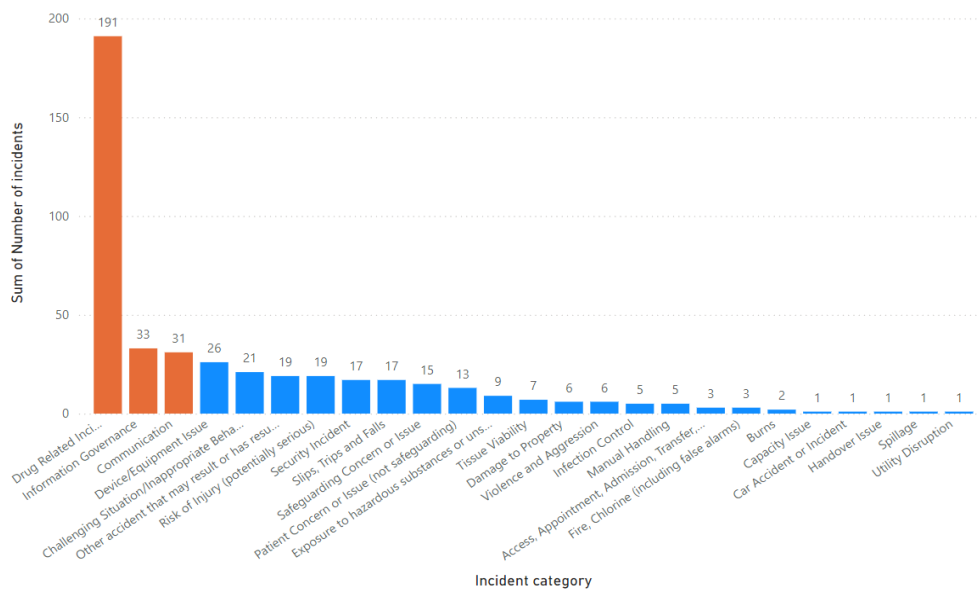
- **PSIRF Engagement Leads** – All care staff Band 7 and above
- **PSIRF Oversight/ Patient Safety Role** – Head of Clinical Quality and Compliance
- **PSIRF Patient Safety Team** – Executive Lead (Medical Director or Director of Nursing and care) Learning response lead, engagement lead representative, and Head of Quality and Compliance

Introduction of a new weekly incident safety huddle meeting which will feed into Helen & Douglas House’s previously existing governance structure to support the PSIRF agenda. A patient Safety Partner role will initially be built into the Head of Quality and Governance role with a review of that role 6 months post-implementation of PSIRF.

4. PATIENT SAFETY PROFILE

The purpose of the patient safety profile is to identify key risks to prioritise quality improvement work in those areas.

Incidents, freedom to speak up, staff surveys, family feedback and exit interviews within the last 3 years were reviewed to analyse Helen & Douglas House’s patient safety profile. The graph below demonstrates the number of incidents reported under each category.



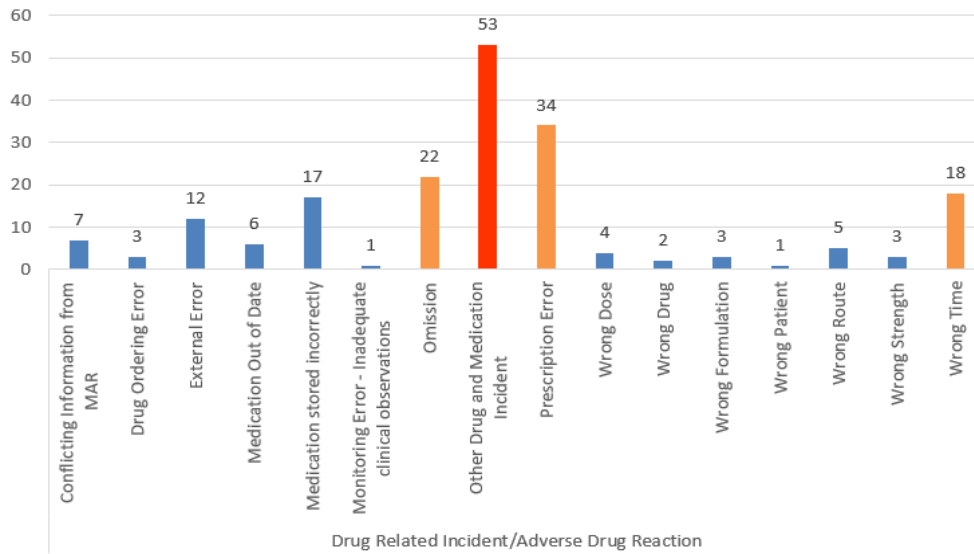
The top three identified risks are drug-related incidents, information governance and communication.

Communication – Highest risk was 10 incidents involving disruption to IT equipment (phones, emails and EPR).

Information governance – Highest risk was 8 incidents relating to data breaches involving electronic transfer of information to non-intended recipients.

Drug-related incidents were our single most reported category, we therefore analysed the sub-categories.

Those were **Omissions**, **prescription errors** and **wrong time** were the highest areas of risk (see graph below).



5. QUALITY IMPROVEMENT WORK

PSIRF is a system-wide approach to how we respond to patient safety incidents and will be fundamental to the wider improvement work Helen & Douglas House is already undertaking. A key component of this will be the greater involvement and interactions of staff and patients with patient safety incidents leading to improved teamwork and a just culture.

6. TRAINING

All staff will receive training in accordance with national requirements. Core staff will be trained by 30th March 2025.

	Level 1 e-learning: Essentials of patient safety for all staff	Level 2 e-learning Access to practice	e-learning Essentials of patient safety for Boards and Senior Leadership	Systems Approach to learning 2 days/ 12 hours	Involving those affected by patient safety incidents in the learning process	Systems approach to Learning - Oversight
All staff	✓					
All clinical staff	✓	✓				
PSIRF learning response leads	✓	✓		✓		
PSIRF Engagement Lead	✓	✓			✓	
PSIRF Oversight	✓	✓		✓		✓
PSIRF Executive Lead			✓			✓
Trustee Board members			✓			

All senior roles requiring specific training will be overseen by the PSIRF Executive Lead, and training compliance for clinical staff will be monitored by the Learning and Development team. PSIRF sessions will be delivered on training days throughout the next 12 months to ensure a seamless transition. Training compliance will be reported to the Clinical Governance Committee and ICB's as requested.

Defining our patient safety incident profile

The patient safety team will attend a weekly safety huddle to review the incidents from the previous week and will decide whether a safety response is required, which response is proportionate, requires further information/ investigation, or the incident can be closed.

The following committees/ groups will also support PSIRF:

- Medicines Management – Quarterly or in response to safety huddle
- Nurse led medicines management sub-group – Quarterly
- Clinical Operations committee – Bi-monthly
- Clinical Governance committee – Quarterly
- Clinical Education committee- Bi-monthly
- Risk review committee – Quarterly or in response to safety huddle
- Safeguarding Steering – Quarterly or in response to safety huddle

Any incidents that are categorised as moderate harm or above post review by the patient safety team, will have a patient safety incident investigation (PSII) completed. Where Near miss or Low Harm incidents where significant learning is identified or required a PSII will be performed. The patient safety team will identify appropriate people to investigate using the Patient Safety (SEIPS)

model. Once the PSII has been completed, this will be reviewed and an invitation will be sent to the ICB quality lead should they wish to attend the review and share the learning further .

Steps needed to embed PSIRF

- Provide appropriate training to all clinical staff as per table above
- Embedding of new patient safety team to meet weekly at safety huddle
- Use safety huddle as the sounding board to encourage the use of appropriate learning tools to look at incidents.
- Produce new documentation for patients, families and staff members involved in patient safety incidents.
- Identify patient liaison support for PSII and ensure they are appropriately skilled and trained Promoting and embedding an open and psychologically safe culture for incident reporting.
- A good understanding how PSIRF differs from previous frameworks like the SI framework.
- Establish a system to monitor the effectiveness of PSIRF implementation.
- Focus on learning from incidents to identify and address systemic issues rather than solely blaming individuals - developing and embedding a no-blame culture.

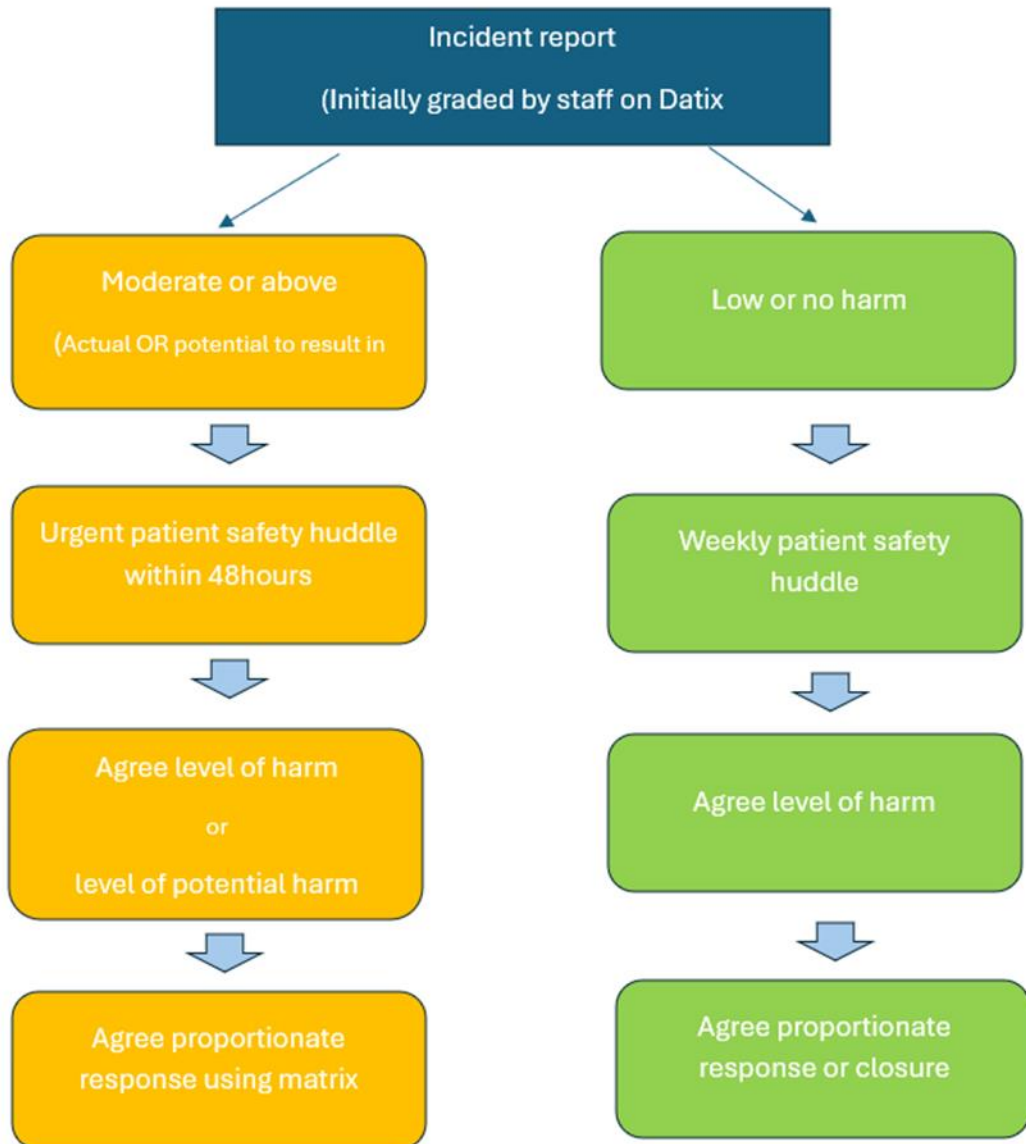
7. OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS

Patient Safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	<p>PSII – as soon as possible after the patient safety incident identified</p> <p>Inform CQC/Charity Commission/ CEO/ICB/ Chair of Trustees/ Insurer within 48 hours</p>	<p>Led by PSIRF Learning Response Lead / Oversight Lead (Not involved or directly line managing those who are involved) Completed within 1-3 months from the start date of allocation using SIEPS. Reviewed at an investigation specific review meeting within 3 months of completion of PSII -where attendance of clinical heads, ICB Quality Lead and relevant external organisations will be requested. Report feeds into the Clinical Governance committee once completed and reviewed. Actions required allocated and logged on Datix with timeframes</p>

<p>Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))</p>	<p>PSII– as soon as possible after the patient safety incident identified</p> <p>Inform CQC/Charity Commission/ CEO/ICB/ Chair of Trustees/ Insurer within 48 hours</p>	<p>Led by PSIRF Learning Response Lead / Oversight Lead (Not involved or directly line managing those who are involved) Completed within 1-3 months from the start date of allocation using SIEPS. Reviewed at an investigation specific review meeting within 3 months of completion of PSII -where attendance of clinical heads, ICB Quality Lead and relevant external organisations will be requested. Report feeds into the Clinical Governance committee once completed and reviewed. Actions required allocated and logged on Datix with timeframes</p>
<p>Deaths of patients where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (events meeting the learning from deaths criteria)</p>	<p>PSII– as soon as possible after the patient safety incident identified</p> <p>Inform CQC/Charity Commission/ CEO/ICB/ Chair of Trustees/ Insurer with 48 hours</p>	<p>Led by PSIRF Learning Response Lead / Oversight Lead (Not involved or directly line managing those who are involved) Completed within 1-3 months from the start date of allocation using SIEPS. Reviewed at an investigation specific review meeting within 3 months of completion of PSII -where attendance of clinical heads, ICB Quality Lead and relevant external organisations will be requested. Report feeds into the Clinical Governance committee once completed and reviewed. Actions required allocated and logged on Datix with timeframes</p>

8. OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS

The flow chart below illustrates the process for the patient safety team to follow on receiving a clinical incident on Datix.



**Please note if on beginning the proportionate response it is identified that more or less harm has been now identified due to further information gathering, the investigator will return to the Patient Safety Huddle to present the new information and the safety team will decide on appropriate action required.*

Patient Safety incident type or issue	Planned response	Anticipated improvement route
Incident resulting in moderate or severe harm after urgent patient safety team review	MDT review within 72 hours PSII – as soon as possible after the patient safety incident identified	-Led by PSIRF Learning Response Lead / Oversight Lead (Not involved or directly line managing those who are involved) - Completed within 2 months from the start date using SIEPS model.

		<ul style="list-style-type: none"> - Reviewed at an investigation specific review meeting within 3 months of completion of PSII -where attendance of clinical heads, ICB Quality Lead and relevant external organisations will be requested. -Report feeds into the Clinical Governance committee once completed and reviewed - Actions required allocated and logged on Datix with timeframes
Where Near miss or Low Harm incidents where significant learning is identified or required	PSII will be performed.	<ul style="list-style-type: none"> -Led by PSIRF Learning Response Lead / Oversight Lead (Not involved or directly line managing those who are involved) - Completed within 2 months from the start date using SIEPS model. - Reviewed at an investigation specific review meeting within 3 months of completion of PSII -where attendance of clinical heads, ICB Quality Lead and relevant external organisations will be requested. -Report feeds into the Clinical Governance committee once completed and reviewed - Actions required allocated and logged on Datix with timeframes
Incident that had potential to result in moderate to severe harm to patient, after patient safety review	MDT review within 72 hours After Action Review within 1 month	<ul style="list-style-type: none"> -Led by Band 7 or above -Learning identified and action plan completed. -Action plan will be tracked by clinical governance committee. Reported to ICB's quarterly. - Actions required allocated and logged on Datix with timeframes
Medication graded as severe harm, after patient safety team review	PSII – as soon as possible after the patient safety incident identified	<ul style="list-style-type: none"> -Led by PSIRF Learning Response Lead / Oversight Lead (Not involved or directly line managing those who are involved)

		<ul style="list-style-type: none"> - Completed within 2 months from the start date using SIEPS model. - Reviewed at an investigation specific review meeting within 3 months of completion of PSII -where attendance of clinical heads, ICB Quality Lead and relevant external organisations will be requested. -Report feeds into the Clinical Governance committee once completed and reviewed Actions required allocated and logged on Datix with timeframes
Medication incident graded as moderate, after patient safety team review	After Action Review within 1 month	<ul style="list-style-type: none"> - Led by Band 7 or above -Learning identified and action plan completed. -Action plan will be tracked by clinical governance committee. Reported to ICB's quarterly. - Actions required allocated and logged on Datix with timeframes
Medication graded as low or no harm, after patient safety team review	<p>Quarterly trend analysis</p> <p>Bi-annual thematic analysis</p>	<p>Patient safety team</p> <p>Medicines management committee</p> <p>PSIRF Oversight Lead to identify trends and learning, with an action plan completed.</p> <p>Action plan will be tracked by medicines management and clinical governance committee. Reported to ICB's quarterly.</p> <p>Actions required allocated and logged on Datix with timeframes</p> <p>Provide thematic learning to ICB for wider oversight</p>

<p>Increase in or multiple theme incidents identified as need for further investigation</p> <p>(3 or more incidents within a quarter, or responsive to a gradual increase)</p>	<p>Discussion at Patient Safety Huddle review</p> <p>Using SIEPS model to identify quality improvement initiatives</p>	<p>Patient safety team</p> <p>PSIRF Oversight Lead to identify trends and learning, with an action plan completed.</p> <p>Action plan will be tracked by medicines management and clinical governance committee. Reported to ICB's quarterly.</p> <p>Actions required allocated and logged on Datix with timeframes</p>
<p>Communication and information governance incidents are the highest reported outside of medications incidents</p>	<p>AAR's will be undertaken on these for the next 12 months to identify learning and improvement opportunities</p>	<p>- Led by Band 7 or above</p> <p>-Learning identified and action plan completed.</p> <p>-Action plan will be tracked by clinical governance committee. Reported to ICB's quarterly.</p> <p>- Actions required allocated and logged on Datix with timeframes</p>

All action plans that are drawn from patient safety responses will be shared with the Clinical Governance Committee, and the patient safety team have responsibility to ensure that action plans are delivered. It is the responsibility of the Chief Executive Officer to maintain oversight of unresolved actions.

**Where internal learning is identified, improvements made, and actions taken at any level of proportionate response consider sharing with ICB and together for shorter lives for other hospice oversight.*

9. RESPONSE LINKED WITH QUALITY IMPROVEMENT PROJECTS LOCALLY

Incident Theme	Incident reporting	Response	Ongoing Quality work
<p>Prescription error and / or administration error</p>	<p>10+ incidents in relation to this area per quarter</p>	<ul style="list-style-type: none"> • Presentation at Patient Safety Huddle • Thematic review • Patient safety team allocate appropriate response/ action planning 	<p>Extra member of care team on admission days to support a more thorough medication reconciliation</p>

			<p>process with parents/ cares.</p> <p>Exploring of nurse-led admissions/ non-med prescribing to relieve medical staff to admit more complex child admissions.</p>
Disruption to IT (emails/ phone/ EPR)	2+ incidents in relation to this area per quarter	<ul style="list-style-type: none"> • Presentation at Patient Safety Huddle • Thematic review • Patient safety team allocate appropriate response/ action planning 	ICT has been outsourced to a whole team who are responsible for all technical support.
Data Breach	2+ incidents in relation to this area per quarter	<ul style="list-style-type: none"> • Presentation at Patient Safety Huddle • Thematic review • Patient safety team allocate appropriate response/ action planning 	

In addition to the responses outlined in the table above Helen & Douglas House is already committed to and will continue to:

- Review themes across all clinical incidents quarterly
- Carry out a 6 monthly desk top thematic review of all medication incidents

10. TOOLS FOR PATIENT SAFETY REVIEW OF INCIDENTS/ GLOSSARY OF TERMS

After Action Review (AAR)

An After-Action Review (AAR) is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.

Multidisciplinary Team (MDT) review (referred to as 'Hot debrief locally')

The multidisciplinary team (MDT) review supports health and social care teams to: identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.

Patient Safety Incident Investigation (PSII)

A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.

Safety Huddle

Safety huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Thematic Review A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews can use qualitative (e.g. open text survey responses, field sketches, incident reports and information sourced through conversations and interviews) as well as quantitative data to identify safety themes and issues.

SEIPS

SEIPS (System Engineering Initiative for Patient Safety (SEIPS) is a framework for understanding outcomes within complex socio-technical systems. SEIPS can be used as a general problem-solving tool (e.g. to guide how we learn and improve following a patient safety incident, to conduct a horizon scan, and to inform system design).

11. SUPPORTING DOCUMENTS

These documents should be referenced in conjunction with this procedure:

- PSIRF policy
- Safety Huddle terms of reference
- Letter to families
- PSII template
- AAR template