Keech Hospice Care

Patient Safety Framework

Incorporating The Patient Safety Incident Response Framework (PSIRF)

Approved by:	**ICB Lead Commissioner and KHC Board of Trustees**
Owned by:	**Deputy CEO/Clinical Director**
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Purpose

The purpose of this framework document is to give the charity clear direction and purpose as to how adults and children are to be kept safe in the hospice's care and that no preventable harm occurs.

Should harm occur, this document sets out the requirements of the Patient Safety Incident Response Framework (PSIRF) and Keech Hospice Care'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 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 document 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 focussed on strengthening response system functioning and improvement.

Scope

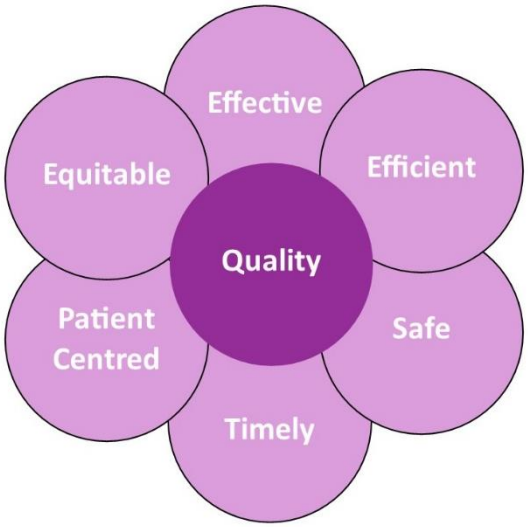
This document is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all adult and children's services, this includes cross system collaboration and learning where more than one provider is involved.

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

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.

The Institute of Medicine (2001) provides an analytic framework for quality assessment which Keech Hospice Care keeps central to its management of patient care.



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.

Related Policies and Procedures

H&S Incidents and Accident Reporting Policy

Whistleblowing Policy

Freedom to Speak Up Policy

Disciplinary Policy & Procedure

Training & Development Policy

Staff Training Requirements

All staff are required to undertake mandatory training subjects relating to patient safety that is relevant to their role, attendance at training is recorded and monitored through the organisations Learning Management System and reported via the Quarterly Quality Report.

See Appendix 1 for PSIRF training requirements.

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 our Quarterly Quality Report.

What Is Harm?

Harm can be defined as any actual or potential ill effects, danger or material damage suffered by an individual. Harm can be deliberate but may also be accidental or caused by negligence. It may be physical, or it may be psychological or emotional.

In healthcare, patients will often be more vulnerable to harm than others owing to their illness. There are many different forms that harm can take in healthcare, such as:

- General harm from healthcare provided
- Acquired infections, falls, and dehydration
- Treatment specific harm – harm that is associated with a specific treatment or the management of a particular disease, for example adverse drug events
- Harm due to over treatment – patients may be harmed from being given too much treatment, either through error for example a drug overdose or from well-intended but excessive intervention, for example treatment at end of life that is painful and not necessary
- Harm due to failure to provide appropriate treatment – this is when the health care professionals fail to provide the appropriate treatment for the symptom, injury, etc.
- Harm resulting from delayed or inadequate diagnosis – staff may not diagnosis an acute situation, or causes of symptom quick enough
- Psychological harm and feeling unsafe – for example, if a patient is made to feel anxious by the behaviour of a health care professional *Vincent et al (2013)*

Patient Safety Culture

Keech Hospice Care promotes a just culture approach (in line with the NHS Just Culture Guide) to any work planned or underway to improve safety culture. Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

We encourage and support incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Please refer to the H&S Accident and Incident Reporting Policy for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

Five Safety Themes at Keech Hospice Care

1. Safety as best practice

- Documented policies and procedures
- Training, competencies, supervision
- Induction for new starters
- Individualised care planning
- Assessment of patient need and evaluation of care
- Discharge planning
- Clinician champions (e.g., management of medicines, infection control, moving and handling, pressure care, patient falls)

2. Improving hospice processes and systems

- Co-ordination of care Standard Operating Procedures
- Incident, accidents and complaints reporting process
- Groups and committees:
    - Clinical Effectiveness Group
    - Clinical Safety and Assurance Group
    - Care Management Team
    - Management of Medicines Group
    - Infection Prevention and Control Group
    - Moving and Handling Group
    - Hydrotherapy Pool Group
    - SystmOne Group
- Audit program
- Continuous Improvement group

3. Risk control

- Staffing levels
- Referral criteria
- Infection control
- Equipment safely used and maintained
- Duty of candour
- Buildings' safety and security
- National Drug Alert and Patient Safety Alert process
- Cognitive aids such as algorithms and prompt cards

4. Monitoring, adaption and response

- PSIRF
- Monitoring of staffing levels
- Use of Establishment Genie
- Transparent, open and honest culture supported by organisational values
- Open discussion of errors
- Patient and family engagement
- Rapid response to acute situations
- Emergency response systems
- Audit program
- Audit and Risk Committee (reporting to Trustee Board)
- Workplace inspections
- Care Safety week with themes to support focus
- Care management meeting and dashboard
- Benchmarking with other organisations
- Quarterly Quality Reports
- Annual PLACE survey
- Annual ICB Quality Reviews

5. Mitigation

- Implementing risk controls to reduce the severity and seriousness of an adverse event
- Leadership
- Whistleblowing Policy and Freedom to Speak Up Guardian
- Annual servicing and equipment checks.

Patient Safety Incident Response Plan (PSIRP)

Our plan sets out how Keech Hospice Care 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. See Appendix 1 – PSIRP.

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

Updated plans will be published on our website, replacing the previous version.

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.

Engaging and involving patients, families and staff following a patient safety Incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). 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.

Involving Patients & Families

We recognise the importance of involving patients and families following a patient safety incident, engaging them in the investigation process. This document reinforces guidance relating to the duty of candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation and improvement planning, unless they express a desire not to be involved. Further guidance in relation to duty of candour can be found by visiting http://www.cqc.org.uk/content/regulation-20-duty-candour this includes detailed information about how patients/relatives should be notified and what support should be provided.

Involving Staff, Volunteers and External Professionals/Stakeholders

Staff and volunteers are encouraged and supported to report patient safety incidents or near-misses, with a shift in focus to incidents which provide the greatest opportunities for learning and improvement. The focus is on improvement not blame to promote a system of continuous improvement and a just and open culture.

Involvement of staff, volunteers and other stakeholders is of great importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset.

It is recognised that this new approach will represent a culture shift for the organisation which needs to provide support and guidance so that staff and volunteers feel 'part of' rather than 'done to'.

On a wider scale, a culture of openness and transparency is supported through incident and accident reporting, clinical supervision, Schwartz Rounds, the Employee Assistance Programme and a robust Whistleblowing Policy.

Responding to patient safety incidents

Patient safety incident reporting will remain in line with organisations Health and Safety Incident and Accident Reporting Policy.

Certain incidents require external reporting to regulators and national bodies such as CQC, RIDDOR and Charity Commission, further detail can be found in the Health and Safety Incident and Accident Reporting Policy.

The PSIRP (see Appendix 1) provides more detail on the types of learning response most appropriate to the circumstances of the incident.

A toolkit of learning response types is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Complaints and appeals

Any complaints relating to this document, or its implementation can be raised with any of the patient safety leads listed below, who will aim to resolve any concerns as appropriate.

Keech Hospice Care patient safety leads:

- PSIRF Executive Lead – Clinical Director/Deputy CEO
- PSIRF Engagement Lead – Clinical Band 8a or above
- PSIRF Learning Response Lead – Clinical Governance & Patient Safety Nurse
- PSIRF Oversight Role – Head of Quality & Governance

All complaints from patients or families will be logged in line with our Complaints Policy.

Equality Impact Assessment (EIA)

Keech Hospice Care aims to design and implement services and policies that meet the diverse needs of our service users, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Equality Act 2010 and aims to promote equal opportunities for all. This policy has been assessed to ensure that no service user receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, race, religion or belief, marriage and civil partnership, pregnancy and maternity.

Equality Impact Assessment	Yes/No	Comments
Does the policy affect one group more or less favourably than another on the basis of		
Age	No	
Disability: Learning Difficulties/Hearing Impairment/Visual Impairment/Physical Disability/Mental Illness	No	
Sex (gender)	No	
Gender Re-assignment	No	
Sexual Orientation	No	
Race	No	
Religion or Belief	No	
Marriage or Civil Partnership	No	
Pregnancy & Maternity	No	
Is there any evidence that some groups are affected differently?	No	

Appendix 1

Patient Safety Incident Response Plan (PSIRP)

DRAFT

Effective date:
Estimated refresh date:

	NAME	TITLE	DATE
Authors	Paula Welsh Sarah Oliver	Head of Quality & Governance Clinical Governance & Patient Safety Nurse	04/10/23

Contents

Introduction

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF) as a foundation for change and as such, it challenges us to think and respond differently when a patient safety incident occurs. It is a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP) and sets out how Keech Hospice Care will respond to patient safety incidents.

PSIRF is designed to promote learning and systemic improvement, moving away from the previous Serious Incident Framework which focussed more on process than emphasising a culture of continuous improvement in patient safety.

This framework is designed to focus on doing investigations in a collaborative way, led by those who are trained to conduct them. It ensures the involvement of patients, their carers, families and staff in an embedded system that responds in the right way, appropriate 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 an emphasis on systemic improvement.

Analysis of our current systems has improved our understanding of our patient safety processes and allowed us to use these insights to develop our PSIRP.

Scope

There are many ways to respond to an incident. Our PSIRP covers responses conducted solely for the purposes of systems-based learning and improvement.

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare.

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 types of response exist to deal with specific issues or concerns, and it is outside the scope of PSIRF to review matters to satisfy processes relating to these, examples of which may include complaints, HR matters, legal claims and inquests.

Keech Hospice Care recognises the benefits of cross system collaboration where more than one provider is involved in an incidents and is committed to participating in cross system learning opportunities.

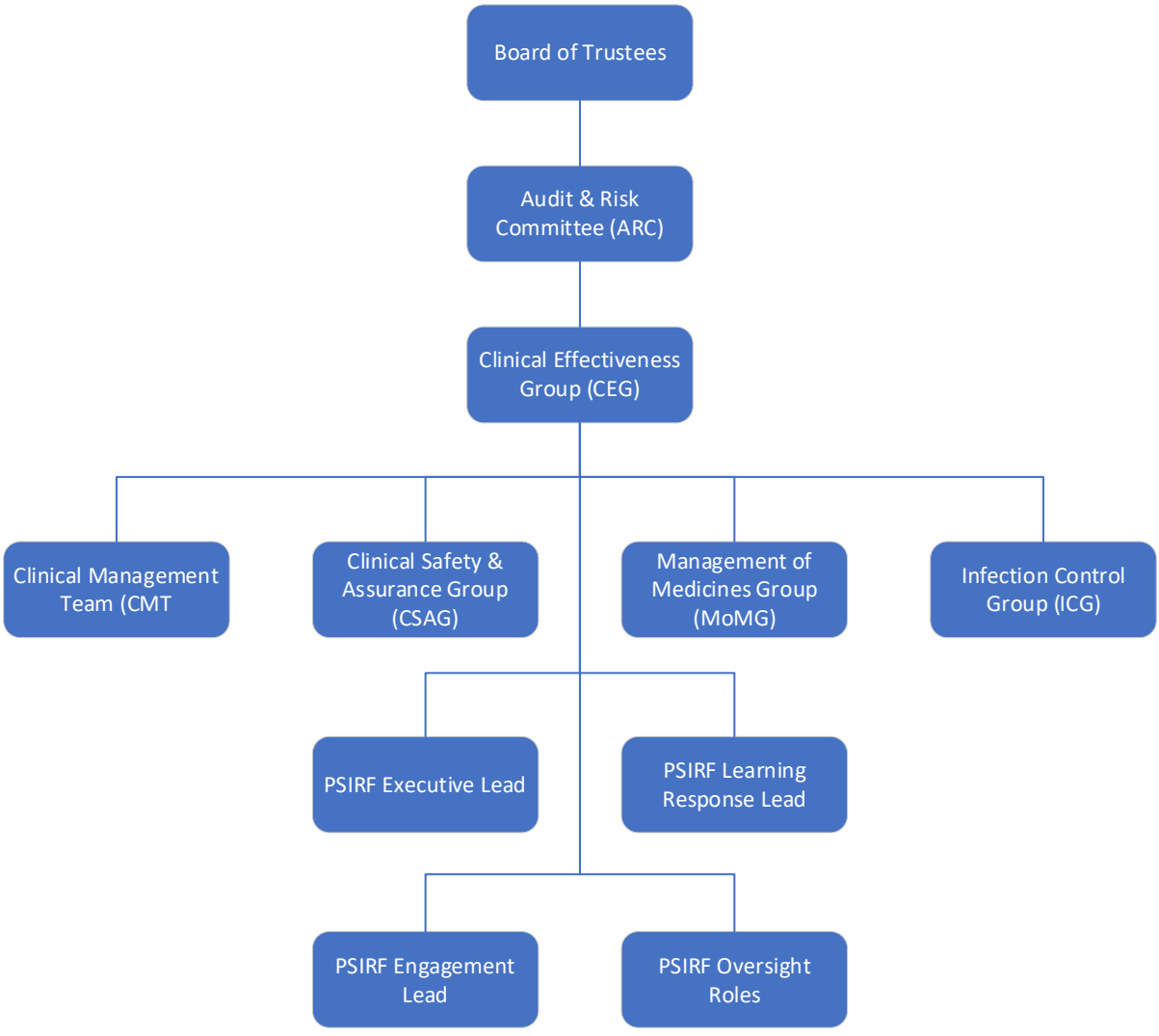
Governance

Keech Hospice Care's mission is to lead the way in providing excellent care, supporting children and adults with life-limiting conditions and those affected by death and dying, helping them to live well and make every day count.

Keech Hospice Care provides both inpatient and outpatient services for adults and children from our site in Luton and wellbeing and support services for adults from our site in Bedford.

Our vision is 'Making the difference when it matters the most'.

Our governance framework for patient safety will support the introduction of the PSIRF plan and initial roll-out, thereafter providing oversight, scrutiny and support to all involved to ensure that those who use our services are protected from harm. We will provide assurance through this framework to demonstrate that learning from incidents and best practice is embedded into our daily routines.

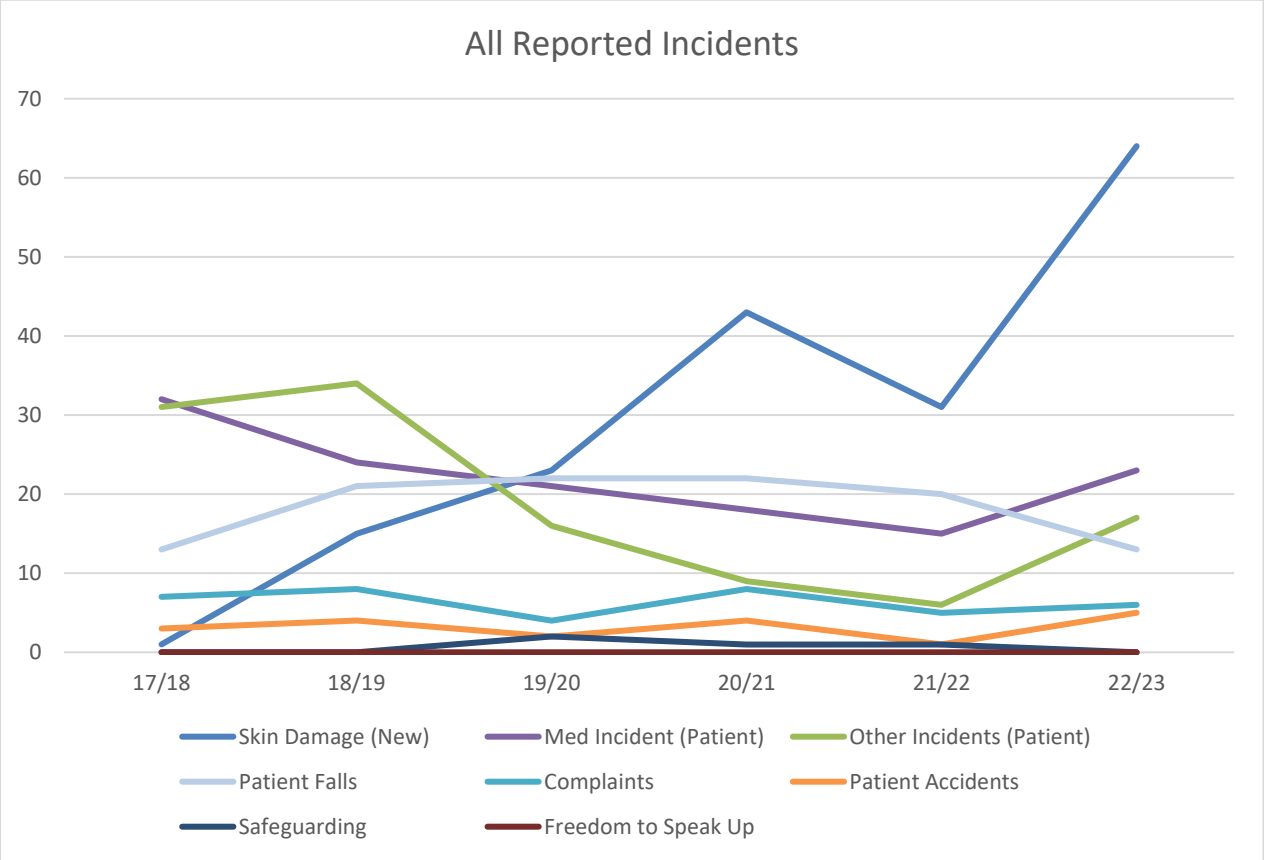


Defining our patient safety incident profile

In order to determine our priority areas to support the delivery of our new PSIRP, we needed to attain an understanding of the scale of patient related safety activity.

To do this we reviewed all of our patient safety data between April 2017 – March 2023, giving us six years of data. The data analysis below identifies the following key patient safety activity:

	17/18	18/19	19/20	20/21	21/22	22/23	Total	%
Skin Damage/PU (New)	1	15	23	43	31	64	**177**	29.7%
Med Incident (Patient)	32	24	21	18	15	23	**133**	22.4%
Other Incidents (Patient)	31	34	16	9	6	17	**113**	19.0%
Patient Falls	13	21	22	22	20	13	**111**	18.7%
Complaints	7	8	4	8	5	6	**38**	6.4%
Patient Accidents	3	4	2	4	1	5	**19**	3.2%
Safeguarding (about Keech)	0	0	2	1	1	0	**4**	0.7%
Freedom to Speak Up	0	0	0	0	0	0	**0**	0.0%



Included in the data above, we have had a total of 6 incidents in this reporting period that have been investigated under the Serious Incident Framework, details of these have been tabled below:

Date	Serious Incident
July 2017	2 patient falls on the adult in-patient unit that resulted in fractures
May 2018	1 x category 3 pressure ulcer
June 2018	1 x patient scald
January 2019	1 x category 3 pressure ulcer
March 2019	1 x category 4 pressure ulcer

We participate in quarterly reporting to Hospice UK, enabling us to benchmark with other hospices against medication incidents, patient falls and pressure ulcers.

In the last 6 years we have had **0** legal negligence claims.

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

Table 1 below sets out the local or national mandated responses that are relevant to Keech Hospice Care.

	National priority	Response
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSll
4	Child Deaths	Refer for Child Death Overview Panel review. Locally led-PSII (or other response) may be required alongside the Panel review - organisations should liaise with the panel
5	Death of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII (or other response) may be required alongside the LeDeR review
6	Safeguarding incidents in which: Babies, children and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism; modern slavery & human trafficking or domestic abuse/violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards
9	Deaths of patients where the Mental Capacity Act (2005) applies, where there is reason to think that the	Locally led PSII by the provider in which the event occurred with STG/ESTH participation if required

	National priority	Response
	death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Any incident resulting in actual Level 3 moderate harm or above (see 'Level of Harm' chart below).	Swarm Huddle completed within 24 hours of incidents and PSII.	Led by PSIRF Learning Response Lead. Completed within 1 month from date of incident. Involvement of patient/client/relatives and staff in developing safety actions and improvement plans. Reviewed by Clinical Safety and Assurance Group (CSAG) who will develop safety action and quality improvement plans. Notification to Care Quality Commission (CQC). ICB Quality Lead informed and reported at relevant ICB Contract Review Meeting. Reported via Quarterly Quality Report.
A safeguarding allegation made against Keech Hospice Care.	As per our Safeguarding Policy and Procedure.	As per our Safeguarding Policy and Procedure.
New Pressure Ulcer category 3 and 4.	PSll to be completed.	Led by Band 8a or above supported by Pressure Ulcer Link Nurse and PSIRF Learning Response Lead. Completed within 1 month from date of incident.

Patient safety incident type or issue	Planned response	Anticipated improvement route
		Notification to Care Quality Commission (CQC). Reviewed by Clinical Safety and Assurance Group (CSAG) who will develop safety action and quality improvement plans. ICB Quality Lead informed and reported at relevant ICB Contract Review Meeting. Reported via Quarterly Quality Report.
New Pressure ulcer category 2, DTI, skin damage caused by Moisture Lesions, Device related injury.	Incident form completed within 2 days of identifying the incident with details of immediate actions taken. After Action Review completed within 14 days.	Facilitated by team leader supported by pressure ulcer link nurse. Reviewed by Clinical Safety and Assurance Group (CSAG) who will develop safety action and quality improvement plans.
Medication Incidents level 0-2	Incident form completed within 2 days of identifying the incident with details of immediate actions taken. After Action Review within 14 days.	Facilitated by team leader as part of incident reporting process. Reviewed by Clinical Safety and Assurance Group (CSAG) who will develop safety action and quality improvement plans, assurance provided to Management of Medication Group. All Controlled Drug incidents submitted to LIN.
Patient falls and other patient accidents/incidents level 0-2	Incident form completed within 2 days of identifying the incident with details of immediate actions taken.	Facilitated by team leader as part of incident reporting process.
	After Action Review within 14 days.	Reviewed by Clinical Safety and Assurance Group (CSAG) who will develop safety action and quality

Patient safety incident type or issue	Planned response	Anticipated improvement route
		improvement plans, assurance provided to Clinical Effectiveness Group (CEG).
Identification of arising trends or themes in any type of incident.	Thematic Review (minimum every 12 months).	Facilitated by PSIRF Learning Response Lead supported by PSIRF Oversight role, involving members of the MDT as required. Reported to Clinical Safety and Assurance Group (CSAG) who will develop safety action and quality improvement plans, with assurance provided to Clinical Effectiveness Group.

Levels of Harm	
Level 0 (Prevented)	Incident prevented from occurring - no harm
Level 1 (No harm)	Incident occurred - no harm
Level 2 (Low harm)	Incident requiring extra observation or minor treatment - low harm
Level 3 (Moderate harm)	Incident requiring treatment/monitoring and causing change to status - moderate harm
Level 4 (Severe harm)	Incident causing permanent harm - severe harm
Level 5 (Death)	Incident directly resulting in the patient's death

This PSIRP will have the flexibility to manage emergent risks or new incidents that signify extreme levels of risk or incidents that don't fall into the outlines national or local categories. Keech Hospice Care will take a pragmatic approach and a proportionate response to maximise learning.

Keech Hospice Care has identified the following key patient safety leads:

- PSIRF Executive Lead – Clinical Director/Deputy CEO
- PSIRF Engagement Lead – Clinical Band 8a or above

- PSIRF Learning Response Lead – Clinical Governance and Patient Safety Nurse
- PSIRF Oversight Role (s) – Head of Quality & Governance

Training

All staff will receive training in accordance with national requirements. Key medical, clinical & AHP staff will be trained by 31/10/23 with remaining relevant medical, Clinical & AHP staff trained by 31/12/23 and the rest of the organisation by 31/03/24.

Table to be populated	**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 Teams**	**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 Hospice staff	✓					
All medical, Clinical & AHP staff	✓	✓				
Band 8 Nurses	✓	✓		✓	✓	✓
PSIRF Executive Lead	✓	✓		✓	✓	✓
PSIRF Engagement Lead	✓	✓		✓	✓	✓
PSIRF Learning Response Lead	✓	✓		✓	✓	✓
PSIRF Oversight Role	✓	✓		✓	✓	✓
Strategy & Governance Cmtee (SLT)	✓		✓			
Trustee Board members	✓		✓			

Review of the Plan

Keech Hospice Care will review this plan every 12-18 months in line with national guidance. If there is a change to the plan, Keech Hospice Care will notify the ICB to agree sign of off the change.

Where there is a cluster or unexpected significant number of incidents, ICB may ask for an earlier review of the plan as appropriate.

Annex 1 - Glossary

AAR – After action review

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 to identify the opportunities to improve and increase to occasions where success occurs.

Deaths thought more likely than not due to problems in care

Incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

Never Event

Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

PSII - Patient Safety Incident Investigation

PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

PSIRF - Patient Safety Incident Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.