Fairfield Independent Hospital

Patient Safety Incident Response Plan

June 2024- June 2025

Approved by IGC Sept 2023

Introduction

PSIRF is a different approach to how we respond to patient safety incidents. With PSIRF, we are responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. There are a set of principles that we will work to.

This patient safety incident response plan sets out how the Fairfield Independent Hospital intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The Hospital is committed to making patient safety its first priority and will adhere to the principles of Duty of Candour in line with the Trust's Being Open and Duty of Candour policy. The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety incident
PSIRF offers us the opportunity to learn and improve and to promote the safe effective and compassionate care of our patients, their families and carers whilst also protecting the well-being of our staff. The challenge of the implementation of PFIRF for an organisation like ours cannot be underestimated.

Our services

Fairfield Independent Hospital provides consultant led general and acute inpatient and outpatient services, a range of diagnostic services and physiotherapy services.
We serve a local population that includes residents of St Helens, Wigan, Halton, Knowsley, Warrington, Liverpool and Lancashire.

The Scope of PSIRF

It is outside the scope of PSIRF to review matters relating to complaints, HR matters, legal claims and inquests.

This Plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

Our patient safety incident profile

We have developed our understanding and insights into patient safety matters over a period of years in order to produce this plan. We have regular Executive-led huddles and hospital wide meetings to discuss incidents and investigations. We have Board level input and a governance framework to support our risk management processes. We see PSIRF as a valuable tool to enable us to continually improve.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements to fully implement the Framework the Hospital has completed a review of what types of patient safety incident have occurred to fully understand what needs to be learned to improve.

Stakeholder engagement

We do not have the luxury of a dedicated PSIRF team. However, the Executive leads have consulted with several PSIRF early adopters to enable us to understand the practicalities of planning for and implementation of PSIRF and their assistance has been invaluable.

PSIRF requires a very different approach to the oversight of patient safety incidents. We have carried out a number of presentations to staff and the Board. Some staff have undergone specific training and we have a rollout programme of training for other staff.

Our data sources and how they were used to define our safety profile is detailed below.

Data sources

To define our patient safety response profile, we drew data from a variety of sources including the currently used incident reporting system and our adverse event data. We moved to collate data on the actual incidents that had taken place over the period of the 4 years prior to 2022, that is, from 2018 to 2021. We decided to look at these 4 years to minimise the possibility of any variation in data arising from the COVID-19 pandemic.

Data and information (both qualitative and quantitative) have therefore been received from the following sources:

- patient safety incident investigation reports
- complaints
- Freedom to Speak Up reports
- Safeguarding reviews
- staff survey results
- claims
- hospital risk profile

The criteria FIH have used for defining the top local patient safety risks is as follows:

- Potential for harm
- People: physical, psychological, loss of trust (patients, family, caregivers)
- Service delivery: impact on quality and delivery of healthcare services;
- Impact on capacity
- Public confidence: including political attention and media coverage
- Persistence of the risk
- Frequency
- Potential to escalate
- Likelihood of occurrence

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.

It should be noted that FIH does not provide mental health, learning disability services, maternity, children's services or custodial services.

The national priorities applicable to FIH services include:

Number	National priority	Response
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PS11
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PS11
3	Safeguarding incidents in which: Babies, child 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. We do not provide services for children

In a nutshell we will ensure that patient safety investigations are conducted to identify the circumstances and systemic, interconnected factors that result in patient safety incidents.

Investigations will analyse the system in which we work by collecting and analysing evidence, to identify systems-based contributory factors. Safety recommendations are created from this evidence-based analysis, to target systems-based improvement.

We no longer search for a single root cause; we look at the different events that occurred leading up to the incident and analyse the possible causes. This will support us in looking at the system and not the people as individuals who work
within it. This is a change in culture from what we do now and how we do it.

Our patient safety priorities:

Based on our data Fairfield Independent Hospital has identified its key safety priorities as:

No	Incident type	Description
1.	Unplanned Transfer of Care	Potential for patient harm as a result of communication with multiple stakeholders for on-going patient care. Delays in transfer of care Deterioration of the patient
2.	Unplanned re-admissions	Potential for patient harm as a result of patient deterioration.
	Medication	Mis-selection of wrong medication or dose leading to harm or potential for harm. Opioids management, Gentamycin/vancomycin, Medication patches, Extravasation, Diabetes medicines management, Thromboprophylaxis
	Unplanned re-admission to theatre	Potential for patient harm as a result of surgical complications. Poor communication Deterioration of the patient

National guidance recommends that 3-6 investigations per priority are conducted per year. These will need to be combined with patient safety incident investigations from the national priorities applicable to the Hospital.

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context, the populations served and the range of services provided . We will use the outcomes to inform our patient safety improvement planning and work.
This plan will continue to be monitored via the hospitals Integrated Governance Committee.

Involvement of patients, families and carers

We recognise the significant impact patient safety incidents can have on patients, their families and carers.
Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

Involvement of staff

When a colleague reports an incident or is providing their insights into the care of a patient for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement. Our new policy, procedures and guidance will support this in practice.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience and we will provide appropriate support to any individual involved.

Appendix A

Glossary of terms

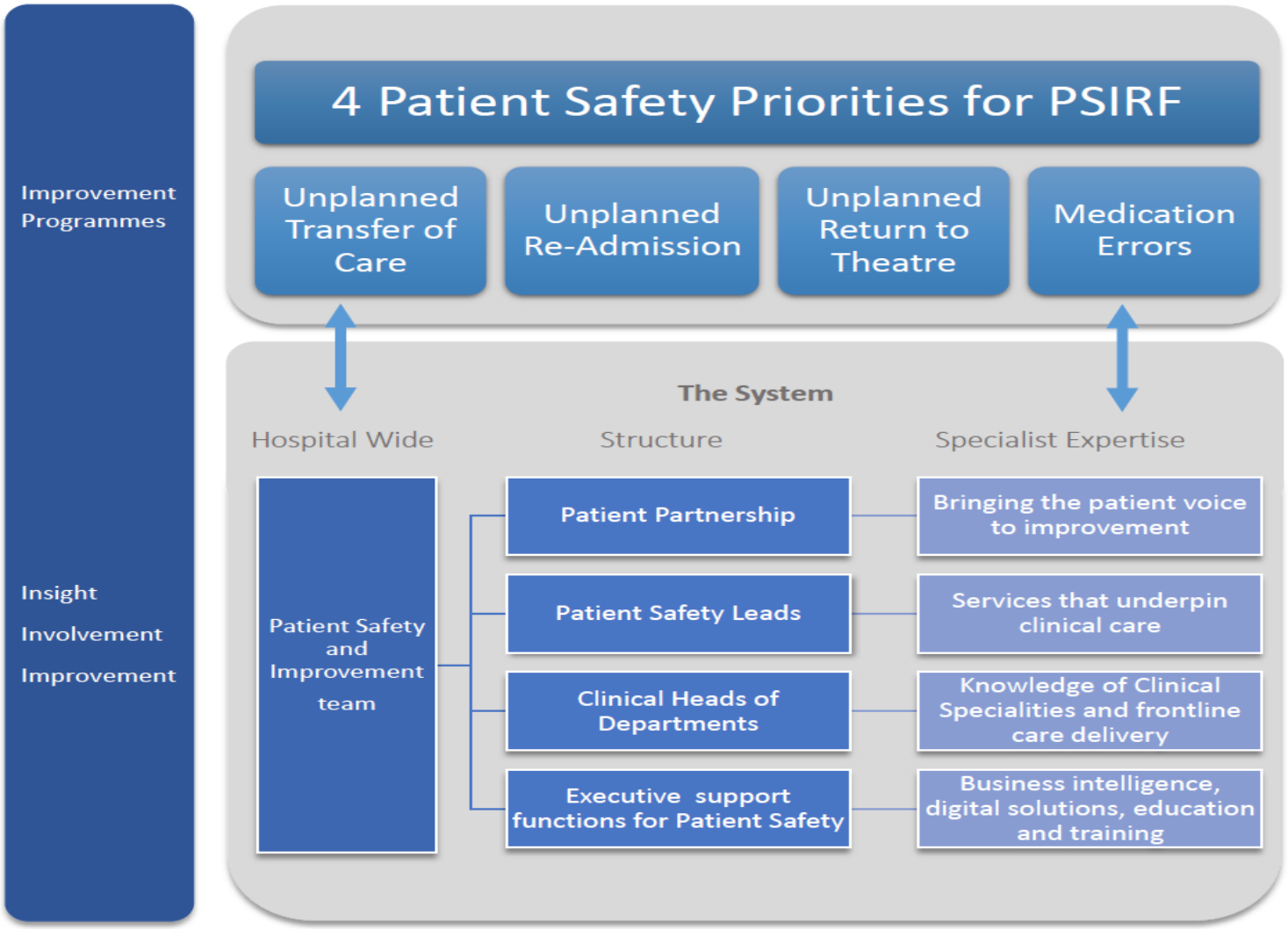
PSIRF - Patient Safety Incident Response Framework
This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, 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.

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.

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.
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

Appendix B


Improvement Programmes
Insight
Involvement
Improvement
4 Patient Safety Priorities for PSIRF
Unplanned Transfer of Care
Unplanned Re-Admission
Unplanned Return to Theatre
Medication Errors
The System
Hospital Wide
Structure
Specialist Expertise
Patient Safety and Improvement team
Patient Partnership
Patient Safety Leads
Clinical Heads of Departments
Executive support functions for Patient Safety
Bringing the patient voice to improvement
Services that underpin clinical care
Knowledge of Clinical Specialities and frontline care delivery
Business intelligence, digital solutions, education and training