# Patient Safety Incident Response Framework (PSIRF) Action Plan

| Version Number | Version date | Author/Reviewer: | Changes made | Approved by |
|---|---|---|---|---|
| 1.0 | Nov 2023 | Helen Bennett, Director of Care and Julie Hughes, Quality and Governance Lead | New | Clinical Committee/SMT<br><br>External approval Frimley ICB |
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## 1.0 Introduction

The Patient Safety Incident Response Plan for Alexander Devine Children's Hospice Service sets out how we intend to respond to patient safety incidents over the next 2 years. The Patient Safety Incident response plan should be read with the Patient Safety Incident Response Framework (PSIRF) policy and related risk management and safeguarding policies. The plan offers direction and we will remain responsive to the specific circumstances in which patient safety and incidents occur.

## 2.0 Our Service

Alexander Devine Children's Hospice provides palliative and end of life care for babies, children and young people and their families both in the community and inpatient. Care is delivered across Berkshire and into surrounding counties through an holistic approach that aims to meet the individual needs of each child and their family.

Our vision is to provide a service that will give children and families a choice of care and support from a dedicated team. Care and support is provided by qualified nurses, nurse specialists in palliative care, carers, specialty doctors, paediatricians, play specialists, counsellors and therapists. The hospice is supported by a team of estates and housekeeping staff. We work within an integrated model of care, working closely with our NHS colleagues.

The Fundraising team are responsible for funding the service and the charity is led by the CEO and Founder supported by the SMT and governed by the Board of Trustees.

The service offers:

- Support for children and families from diagnosis
- Day care
- Respite care and short breaks
- Play and music therapy
- Physiotherapy
- Crisis and emergency care
- Assessment and symptom management
- End of life care
- Family support
- Bereavement support

## 3.0 Defining our patient safety and incident profile

The identified priorities have been agreed through stakeholder engagement and identified actions following a PSIRF training event. Implementation of the PSIRF is a key area of our Quality and Improvement plan 2023-2024 and aligns to our strategic priorities:

1. Providing high quality care to all children and families that use our service, to ensure families have choice of care and positive outcomes.

Following the publication of the new Patient Safety Incident Response Framework we undertook specific training within the organisation to identify areas of improvement. This was also informed by the thematic analysis of incidents over the last 12 months. We have also linked with both the Frimley and BOB integrated care board, patient safety forum to support the development and implementation of PSIRF.

We currently have an incident reporting framework and comprehensive risk assessment and reporting in place. This has provided an underpinning benchmark for the implementation of PSIRF.

Our aim is to establish an identified profile and framework with a proportionate response to incidents that will include:

- Internal investigation eg The Systems Engineering Initiative for Patient Safety (SEIPS) or swarm huddle/MDT
- Governance Lead to disseminate national safety alerts
- Thematic analysis

- Patient Safety Incident Investigation (PSII)
- Links with the ICB quality group Patient safety forum

Evidence that improvement work has the intended benefit to be effective will be demonstrated through our audit programme. Summary of the PSIRF in practice is shown in figure 1.

## 4.0 Incident Response Plan

The implementation of PSIRF is outlined in table 1 and the incident types identified with appropriate response to understand the learning and need for improvement - Table 2.

The process and response to patient safety incidents will be managed in a timely and robust way (see figure 1)

**Table 1: Implementation of PSIRF**

| Actions | Outcome | Comment/improvement | Timeframe |
|---|---|---|---|
| Implementation of PSIRF<br>• Review of current patient safety policy and process<br>• Identify priorities for implementation and engagement<br>• Identification of key roles and responsibilities; response lead and engagement lead<br>• To integrate reporting systems including, incidents and 'freedom to speak up' | • Robust system and process for patient safety<br>• That all staff understand their engagement in relation to the new framework<br>• Open and transparent reporting<br>• Embedded tools to support a 'just culture<br>• Improvement of patient experience | • Policy developed and sign off with Frimley ICB<br>• Training for senior staff to support shared learning and implementation | By sept 23 |
| Engagement with all those affected by an incident<br>• Increased engagement with services users including Children and young people<br>• Feedback from newly developed parent forum<br>• Team meeting to inform and share learning with all staff | Following an incident families and staff report satisfactory experience of communication and engagement<br><br>MDT response – open discussion and swarm huddle | • To draw on findings from stakeholder engagement and patient / family surveys | By Apr 24 |
| | Effective implementation of PSIRF to ensure patient safety | Risks already well understood and | By April 24 |

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| Review processes for reporting and investigating incidents and response<br>(Patient safety incident investigation PSII) see table 2<br>• Incident type and which will be investigated thoroughly<br>• Responding proportionally – response methods – analysis using SEIPS and thematic analysis<br>• Understanding contributory factors | | comprehensive systems in place to mitigate risks within ADCHS<br>Proportionate response to incidents | |
| Learning from incidents<br>• After action review (AAR)<br>• Completion of PSIRF investigation at least twice yearly<br>• To monitor local and national priorities | Learning to inform improvements | Quarterly review of all incidents, actions and learning | Sept 24 |
| Reporting and mapping using Vantage module | Effective use of data system to support development and improvements related to patient safety | Record actions taken | Sept 24 |
| To seek opportunities for further learning and sharing information including training for all staff<br>• Engagement with ICB | Greater knowledge and understanding of PSIRF and robust systems and processes undertaken | Networking to support the development and learning for PSIRF | Sept 24 |

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| • Specific training for response leads and engagement leads | | | |

**Table 2 Incident response plan**

| **Patient Safety Incident Type** | **Response**<br><br>***To include:***<br>*Internal investigation eg SEIPS or swarm huddle/MDT*<br>*Governance Lead to disseminate national safety alerts*<br>*Thematic analysis PSII*<br>*ICB quality group*<br>*PSII* | **Improvement work** |
|---|---|---|
| Medicines | • National patient safety programme<br>• Internal medicines management monthly meetings<br>• Thematic analysis | Risks already well understood and comprehensive systems in place to mitigate risks within ADCHS.<br>Contract with Frimley Pharmacist.<br><br>New role of CDAO (Controlled Drugs Accountable Officer) and policy and SOPs to support safe management of CD's.<br>Participation in Controlled Drug Local Intelligence Network (CDLIN). |
| Safeguarding | • LADO (Local Authority Designated Officer)<br>• Social care<br>• ICB safeguarding team | Recently introduced safeguarding strategy. To ensure sharing of knowledge across the wider organisation including directors and trustees. |

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| | | Understanding responsibilities of freedom to speak out and Development of freedom to speak out training across the organisation. |
| Staffing | • SMT<br>• CQC | To sustain safe levels of staffing. Continued monitoring of acuity, capacity and skills.<br>Regular reporting through stated governance structure.<br>Robust recruitment strategy. |
| Clinical Care | • Internal clinical governance<br>• Patient Safety alerts<br>• Thematic analysis | Constant review and dynamic risk assessment to inform improvements in clinical care. |
| Transfer of patients through a pathway of rapid response for children reaching end of life | • Cross organisational wide systems to support pathways of care<br>• External debriefs | Improved operational practice and flow in the rapid transfer across settings.<br><br>Development of Checklist and Partnership SOP's.<br><br>Monitoring of communication and sharing of information. |
| Transition of young people to adult services | • Transition pathway<br>• Situation, Background Assessment and Recommendation tool (SBAR) | Improved networking between child and adult palliative care services to improve pathways of care for young adults |
| Never Event | • PSII | |
| Child Death | • Child death review | Child death overview |

**Figure 1 Patient safety Incident Response Flow Diagram**