Patient Safety Incident Response Plan 24/25

	NAME	TITLE	SIGNATURE	DATE
Author	**Rhiannon Harding**	**Compliance Manager**		
Reviewer	**Mani Neelamegan**	**Director**		
Authoriser	**Mani Neelamegan**	**Director**		

Effective date:

Review date:

Contents

Introduction

In March 2020, NHS England (NHSE) published The Patient Safety Incident Response Framework (PSIRF).The PSIRF is a key part of the patient safety strategy(NHSE2019) and supports the NHS to improve its understanding of safety by drawing insight and learning from patient safety incidents.

The PSIRF replaces the serious incident framework (2015) and makes no distinction between 'patient safety incidents' and 'serious incidents' and their associated thresholds no longer exist under PSIRF. PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement (NHSE, 2022).
PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Application of the Patient Safety Incident Response Framework (PSIRF) principles is mandatory for all health services contracted under the NHS Standard Contract. This includes all aspects of NHS-funded healthcare provided by organisations that are not NHS trusts or foundation trusts, including some services delivered by primary care and NHS funded care delivered by independent organisations.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. As a practice/provider, we have a low threshold for capturing and collating events where the absence of a response may lead to risk to patients and members of the public.

This patient safety incident response plan sets out how Ann Physiocare intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is a fluid document that may change with emerging themes and trends. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. We will continue to learn from the patient safety incidents reported by colleagues, patients, and their families as part of our work thereby continually improving the quality and the safety of the care we provide.

This plan is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Ann Physiocare. All areas of service within this provider are covered by this policy including NHS, corporate and private service lines.

This plan will assist us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

- Refocusing our PSIIs towards a systems approach in line with the PSIRF and the identification of connected causatory factors and systems issues.
- Focusing and addressing these factor to prevent or continuously and measurable reduce repeat patient safety risks and incidents.
- Transferring the emphasis so that we have high quality PSIIs so that it increases our stakeholder's (patients, families, and colleagues) confidence in the improvement of patient safety through learning from incidents.
- Demonstrating the added value of the above approach.
- Ensuring our plan reflects the needs and actions required within the national framework.

We will continue to develop the planning aspects of this PSIRP with the assistance and approval of our integrated care board.

The aim of this approach is to continually improve. As such this document will be reviewed annually and endorsed by the senior leadership team at Ann Physiocare and ratified by the Mani Neelamegan.

Ann Physiocare has a low volume of impact Patient Safety Incidents. This is due to nature of the organization and the service user profile needs. The physical response to treatment varies and cannot be predicted as every individual is different. The key themes or our Patient Safety Incidents are discomfort or aggravation of the existing condition following treatment. However, all therapists discuss potential discomfort that could be caused and consent form is signed prior to treatment being provided.

Our Services

Ann Physiocare provides a range of physiotherapy serviced for individuals, businesses and insurers as an independent provider. Our emphasis is to provide our client with the skill and motivation to self manage their problems and to rapidly become independent from therapy.
Service we provide include:-

- Musculoskeletal Physiotherapy
- Neurological Physiotherapy
- Occupational Health Physiotherapy
- Online Physiotherapy
- Home Physiotherapy
- Functional Capacity Evaluation
- DSE Assessments

From the initial contact to the point of discharge, we aim for the process to be as easy as possible for the client. We have an Admin Team available via telephone, email or whats app, we also have a live online booking system for easy of convenience. Our services are carried out by expert physiotherapists, who asses and provide a treatment plan tailored to the client's needs. We use a online platform to share and distribute exercises to our clients so that it is easily accessible from home or from an alternative location.

Ann Physiocare understands that on occasions things can go wrong or clients will share their dissatisfaction. All complaints are handled and investigated by our in house Compliance Manager.

Internal Stakeholders

The list of internal stakeholders for Ann Physiocare would include representatives from different clinical and non-clinical staff (e.g. Senior Leadership Team, Integrated Governance, Safeguarding, People Team, Health and Safety, and operational management teams).

External Stakeholders

Depending on the incident to be investigated, the external stake holder may vary dependent on their subject matter expertise.

This may include patient groups, and patient and public representative organisations, for example:

- HCPC
- Local Council Safeguarding Team

Defining our Patient Safety Profile

Patient safety issues will be recognizable as soon as it occurs. Concise and comprehensive investigations will soon determine as to the root cause, either system based or human related and what can be done to redress the failure and ensure it does not reoccur.

Where it is unclear as to whether the current incident falls into the category of patient safety incident, senior management and investigators may begin an investigation to agree the appropriate and proportionate response.

These incidents are including but not limited to:-

- Incidents identified in the course of providing a service which may or may not lead to distressing/catastrophic outcomes
- Allegations or concerns expressed about the Company and its business partners
- Initiation of other investigations e.g CSP, HCPC, police investigation etc
- Complaints
- Whistleblowing
- Prevention of Future Death Reports – Coroner

It may be appropriate to record it as a patient safety incident in certain situations. Just because the full severity of the situation wasn't experienced, it's important to consider the replication of the event if a full investigation and address is not performed. This would be based on:

- The likelihood of the incident occurring again if current systems/process remain unchanged; and
- The potential for harm to staff, patients, and the organisation should the incident occur again.

Responses to any patient safety investigation 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 i.e. equipment processes etc and not from a single component alone. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error' are stated as the root cause of an incident.

There is no remit within patient safety investigations to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes exist for the purpose of investigating the following:

- Complaints management,;
- claims handling,;
- human resources investigations into employment concerns,
- professional standards investigations,
- coronial inquests; and,
- criminal investigations.

The principle aims of each of these responses differ from those of patient safety responses 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.

This plan replaces Ann Physiocare's Serious Incident Policy. This plan supports the requirements of the PSIRF and sets out this organisation'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 coordinated and data-driven response to patient safety incidents. It embeds the concept of a patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This plan 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 arrange of system-based approaches to learning from patient safety incidents.
- considered and proportionate responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening response system functioning and improvement.

The plan applies to Ann Physiocare and all its employees and must be adhered to by all those who work for the organisation.

This plan is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across insert Ann Physiocare.

Responses under this plan 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 in actions 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.

Defining our Patient Safety Improvement profile

Ann Physiocare has continuously reviewed and enhanced its governance processes to ensure it not only fully adopts but learns from patient safety incidents.

This feeds into our quality improvement activity and the Clinical governance framework. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholder to identify, define and refine the quality improvement work that must be undertaken. There steps taken to improve patient safety are as follows:

- Auditing medical and administrative records – this will help identify risks and hazards to patients.
- Conducting regular training or focus groups – this will help identify risks prior to them happening and how they can be avoided.
- Clinical Shadowing – therapists to be regularly shadowed by their line managers to help ensure their roles are being completed to a high standard and in turn minimizing risk to patients.
- Reporting events in a timely manner – Reporting events can prevent the risk occurring again.
- Ensure appropriate equipment is present – to ensure treatment is completed in a safe way.
- Review of company policy – full review of company policies are completed annually and shared with all staff – eg Hygiene, Patient Safety.

In line with the national PSII standards the following resources have been identified to enable delivery of the potential investigation programmes, that is:

- National priorities:
    - Never Events
    - Learning from deaths – related incidents
    - Unexpected incidents which signify an extreme level of risk for the patients, families and carers, staff, and organisations, and where potential for learning and improvement is so great (within or across a healthcare service/ pathway) that they warrant the use of additional resources to mount a comprehensive PSII response.
- Identified local priorities
- Excluding incident types that are already part of an active improvement plan that is monitored to determine efficacy and for which incremental improvement can be demonstrated.

Investigation stages

Insert table / dialogue to outline the various stages of the investigation process and the resource required for each PSII. The exact resources will depend on the specific incident.

1. Plan the investigation
2. Gather and map the information (WHAT happened)
3. Identify problems (HOW it happened and variations from what was expected to happen)
4. Analyse contributory and causal factor (WHY these key problems arise)
5. Write investigation report – with clarity, openness and in full consultation with patient/ family and staff.
6. Develop recommendations and action plan.

Safeguarding requires consideration throughout all patient safety events. Whilst there are some specific incidents that will follow the specialty nursing pathway for review, others may require safeguarding input or referrals.

The Mental Capacity Act (MCA, 2005) also requires specific consideration throughout all patient safety events. An individual's capacity to consent or ability to make an informed decision relating to care/treatment may influence their level of involvement in learning responses.
The role of both safeguarding and MCA will be reviewed by the Ann Physiocare's safeguarding lead who attends the Ann Physiocare Managerial and PSIRG meetings.

Our organisation has established a Local IPC Review Plan that is in accordance with the national PSIRF methodology. We ensure the availability of qualified IPC professionals and the necessary tools by allocating adequate staffing and resources to facilitate effective IPC communication and governance.

Our Patient Safety Incident Response Plan: National Requirements

Due to the nature of our business currently it is unlikely that Ann physiocare will be involved in any Patient Safety incidents as outlined in the national priorities.

Our Patient Safety Incident Response Plan: Local Focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Safeguarding Concerns. Eg physical, sexual or emotional abuse. Discrimination or exploitation.	PSII, Internal Review, Refer to safeguarding	- Incident review Process. - Improvement plans. - Refer to Local designated safeguarding officer.
Staff Conduct/Behaviour. Eg – misconduct, gross negligence, violence.	PSII & Internal review	- Internal investigations - Improvement plans - Internal training - Clinical shadowing/Training - Notes audit
System Issues resulting in a delay to providing assistance to clients. Eg – diary issues or system down time resulting in delays in starting treatment.	Internal Review	- Improvement plans. - Ensure continuity of care to patients.
Clinical treatment – High risk incidents. Eg – Diagnostic errors, patient falls or unsafe practices.	PSII or internal review	- Internal investigation. - Notes Audit - Internal Training - Clinical Shadowing/Training

Safety Improvement Plans

The type of response to a local PSII would depend on:

- the views of those affected, including clients and their families.
- Capacity available to undertake a learning response.
- Available resources to share the learning.
- What is known about the factors that lead to the incident(s).
- Whether improvement work is underway to address the identified contributory factors.
- Whether there is evidence that improvement work is having the intended effect/ benefit
- If Ann Physiocare and it's lead ICB are satisfied, risks are being appropriately managed.

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. They can take different forms and may include:

- Creating an organization-wide safety improvement plan summarizing improvement work.

- Creating individual safety improvement plans that focus on a specific service, incident type or situation.
- Collectively reviewing output from PSII's of single incidents when it can be evidenced that there are underlying, interlinked system issues.
- Creating a safety improvement plan to tackle broad areas for improvement (i.e. overarching system issues).

Ann Physiocare will decide upon the best approach to take as an outcome based on the available data following a PSII. This may be to follow up a single plan or if complex be a mixture of the above.

Safeguarding

Safeguarding requires consideration throughout all patient safety events. Whilst there are some specific incidents that will follow the specialty nursing pathway for review, others may require safeguarding input or referrals.

The Mental Capacity Act (MCA, 2005) also requires specific consideration throughout all patient safety events. An individual's capacity to consent or ability to make an informed decision relating to care/treatment may influence their level of involvement in learning responses.

The role of both safeguarding and MCA will be reviewed by the Trust safeguarding team who attend the Trust IRG and PSIRG meetings.

IPC

Our organisation has established a Local IPC Review Plan that is in accordance with the national PSIRF methodology.

We ensure the availability of qualified IPC professionals and the necessary tools by allocating adequate staffing and resources to facilitate effective IPC communication and governance.

Medicines Optimisation

Medicines Safety is committed to the avoidance of harmful events and has an established culture of learning from patient safety incidents.

Medicines are integral to patient care and the learning from patient safety events is a core function for all organisations delivering healthcare services.

Healthcare professionals delivering the medication safety agenda in their organisation require an understanding of national policy, frameworks and legislation. Embedded in all learning response pathways will be the inclusion of subject specialists informing the review process and identifying improvement strategies. In instances where medicines safety incidents are identified, our investigation process will involve collaboration, and any insights derived from these investigations will be disseminated throughout the organisation to facilitate collective learning and improve our practices.

Review Frequency

Rhiannon Harding, the Compliance and Resource Manager, will review this plan after 6 months and 12 months and then annually thereafter in line with national guidance. If there is a change to the plan, Rhiannon Harding or Mani Neelamegan, The Managing Director, will notify the ICB to agree the change sign off.