Patient safety incident response Policy

Including Patient Safety Plan

Effective date: January 2025

Estimated refresh date: 12-18 months March 2026

	NAME	TITLE	DATE
Author	**Sara-Marie Black**	**Chief Operating Officer** **Patient Safety Lead St Rocco's Hospice**	**16/1/25**
Reviewer	**NHS Cheshire and Merseyside Integrated Care Board (ICB) Safety and Improvement Panel** **Quality and safety Sub-committee St Rocco's Hospice**	**C&M ICB** **Quality and safety Sub-committee St Rocco's Hospice**	**16/1/25**
Authoriser	**The plan has been reviewed, and a meeting of the NHS Cheshire and Merseyside Integrated Care Board (ICB) Safety and Improvement Panel has also taken place on 9th January 2025. The members of the panel consisted of the following ICB members:** **Richard Crockford – Associate Director Nursing & Care (Patient Safety)** **Julia Chambers – Patient Safety Lead, Central** **Kirsty Lorimer – Clinical Quality & Improvement Manager, Central** **Helen Monaghan – Quality Manager, Halton & Warrington Place**	**C&M ICB** **CEO and St Rocco's Board**	**23/1/25**

Contents

Introduction

This patient safety incident response policy sets out how St Rocco's Hospice intends to respond to patient safety incidents over a period of 12 to 18 months. This policy includes the patient safety incident response plan which guides how this policy will be implemented.

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across St Rocco's Hospice.

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.

Scope

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.

Outside the scope of the patient safety incident, response plan, which would be any response that seeks to find liability, accountability or causality that is beyond the scope of this policy. This could be the following:

- Complaints,
- Human resources investigations,
- Professional standards investigations,
- Coronial inquests,
- Criminal investigations,
- Claims management,
- Financial investigations and audits,
- Safeguarding concerns,
- Information governance concerns,
- Estates and facilities issues

These would need to follow St Rocco's Hospice policy and procedures and logged via Vantage, St Rocco's incident reporting and risk management system software. St Rocco's Hospice considers other policies and procedures as separate form any patient safety investigation and although information can be shared, as appropriate, from a patient safety response process other processes should not influence the remit of a patient safety response. We recognise that patients, families and our community may wish to raise concerns and complaints, and our complaints processes will not influence the remit of the patient safety response. The hospice is committed as part of our complaints process to recognise, where appropriate, to signpost to other forms of support; including Healthwatch Warrington, an independent statutory body who can support to help make a complaint, Parliamentary and Health service Ombudsman and Citizens advice. This information is available in our complaints policy and leaflet.

This policy and plan support the requirements of the Patient Safety Incident Response Framework with the Hospice Incident Reporting & Management Policy & Procedure 165.

Our Services

St Rocco's Hospice provides care for patients aged 18 and over, with a life limiting diagnosis, and those important to them. The Hospice offers services for the population of Warrington, an approximate population of 230,000 people. The demographic of the area shows most people are born in England and there are a very small percentage of people from other nationalities.

St Rocco's provides clinical care in the 10 bed in patient unit, outreach services within the Vitality Centre and outreach services within the community.

The inpatient unit, clinical model includes specialist nursing, medical and allied health professionals and has ten individual bedrooms, all with ensuite facilities. Volunteers support the delivery of services across the hospice.

Outreach services provided by the hospice include, Palliative Virtual Ward, Integrated Palliative Care Hub, Therapy, Complimentary therapy services, medically led outpatients' clinics, Counselling and Emotional Care team, including 2 community-based Bereavement cafes.

St Rocco's employs more than 150 staff, many who live in the borough and is supported by over 500 volunteers.

Defining our patient safety incident profile

The Hospice has a commitment to continuous learning from patient safety incidents and has over the years continued to develop further understanding and insights into patient safety. The Hospice has continued to work collaboratively with partners in the development of patient safety learning incidents and action plans.

The Hospice Senior Clinical Team meet daily and are alerted to clinical incidents. The Clinical Lead, Quality Lead and Chief Operating Officer are alerted by email of any clinical incidents. Following review by the Clinical Lead and/or Quality Lead the Chief Operating Officer and/or Medical Director will be notified via email for a Senior Manager review.

Quarterly incident trends and any identified learning themes are reported to Quality and Safety subcommittee, and actions presented. Incident reporting is compared to year-on-year incident reporting for comparison of any trends and themes. Subsequent sharing is presented at quarterly CQPG meetings.

This Patient Safety Incident Response Policy and Plan supports the requirements of the NHS Patient Safety Incident Response Framework 2023 (PSIRF) and sets out St Rocco's Hospice (SRH) 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 plan, in line with the 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 safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

This plan should read in conjunction with our patient safety incident response policy.

Stakeholder engagement

Planning for PSIRF was commenced early, in recognition of both the expected demands, and limited resources within a hospice setting to respond. SRH had the opportunity to work closely with ICB Patient Safety Lead and local acute setting Patient Safety Project Lead at Warrington and Halton Hospital, an early adopter of PSIRF.

The Chief Operating Officer (COO)/ Patient Safety Lead and Quality and Safety Coordinator engaged with key stakeholders, both internal and external. Internal data was reviewed to identify any trends and current actions in place. The data profile over the last 2 years was reviewed to identify the top reported incidents. Quality improvement over the last 2 years was also reviewed as part of this process to ensure a focus on prioritised and any further areas for learning and development were prioritised. The proposed plan has acknowledged limitations due to the number of incidents reported as a small independent provider. To mitigate this further the COO engaged with the North West Hospice Clinical Directors Network. Reporting of patient safety incidents quarterly to Hospice Uk also provides a benchmark.

Regular contact with Place has seen this approach progress and provide assurance to Place Patient Safety Lead and internal and external stakeholders.

Formal reporting of the PSIRF implementation has been included in quarterly contracts meetings, to provide assurance.

Training

An initial approach to engage internal teams, was adopted by St Rocco's through the cascade of Patient Safety Level 1 training. This training was delivered in small groups of teams and enabled richness in learning and discussions of teams. The hospice has committed to ensuring we fully embed PSIRF and meet its requirements and support our teams through the cascade and commitment for staff to have time to attend training.

Patient Safety Level 2 training is completed by Line managers and all clinical teams. Further support and training is provided, as per the National patient safety Guidance (appendix D).

The leading response leads will be the Quality and governance lead and Chief Operating Officer who will both have undertaken a minimum of patient safety syllabus training and 1 day face to face training. The learning response leads will undertake continuous professional development on incident response skills and knowledge.

Records of training are maintained on our training reporting system, Blue stream, and reviewed monthly by the Chief Operating officer and reported quarterly at People sub-committee and Quality and Safety sub-committee.

Data sources

To define our patient safety response incidents over the last 2 years were collated and reviewed. Clinical Directors across Northwest Collaborative shared incident data trends to support a wider data set within the Hospice setting and supported as part of the Hospice UK benchmarking and patient safety. Learning from previous incidents and actions put in place were also taken into consideration as part of the data review.

This led to the local focus priorities for review under PSIRF.

The identified PSII is not a fixed plan and where new risk emerges, and improvement can be gained from investigation of a particular incident, an additional ad-hoc PSII will be undertaken.

Defining our patient safety improvement profile

At St Rocco's Hospice we are committed to embedding a culture of continuous improvement to provide the best care possible for our patients. We do this by working together and continually building on the great care that we already provide and striving to make continual improvements for our staff and patients.

The Hospice has developed its incident reporting and governance processes to ensure that the learning from patient safety incidents feeds into continuous improvement of care. The Hospice also draws on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, Hospice UK, partner providers and other key stakeholders to identify and define continuous improvement work we need to undertake to maintain patient safety and best practice.

We will maintain a flexible and responsive approach and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Our patient safety incident response plan: national requirements

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the hospice fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed.

For clarity, all types of incidents relevant to the Hospice setting, that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below.

National priority	Required response
Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII
Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the Panel review
Safeguarding incidents in which: Babies, child and young people are on a child protection plan; looked after plan or a victim of willful 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, child safeguarding practice reviews, 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.

Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.
Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	Locally led PSII by the provider in which the event occurred with Hospice participation as required
Mental health related homicides	Referred to the NHS England and NHS Improvement Regiona Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and WHH participation if required
Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through analysis of patient safety insights, based on the review of incidents and networking with North West Hospice Collaborative clinical directors and place patient safety leads the hospice has determined 1 patient safety priority as a local focus. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

We will use the outcomes of Learning Responses and PSII's to inform our patient safety improvement planning through continuous improvement.

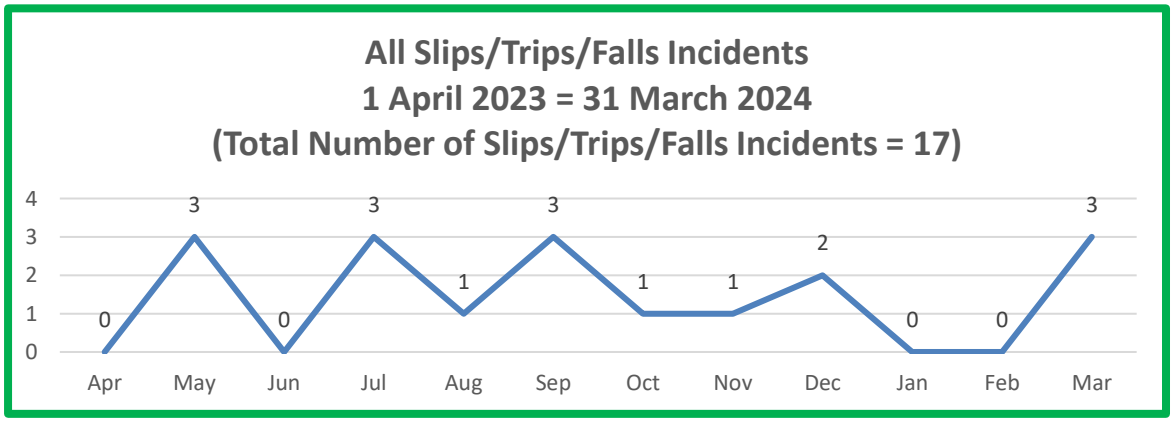
St Rocco's local policy will focus on the areas of concern following a review of the previous 2 year incident data, rather than already understood incidents and where improvement plans are in place. We predict a maximum 12 learning responses per year. If this number of learning responses rises we will commit to review our patient safety incident response plan local focus earlier than the planned review.

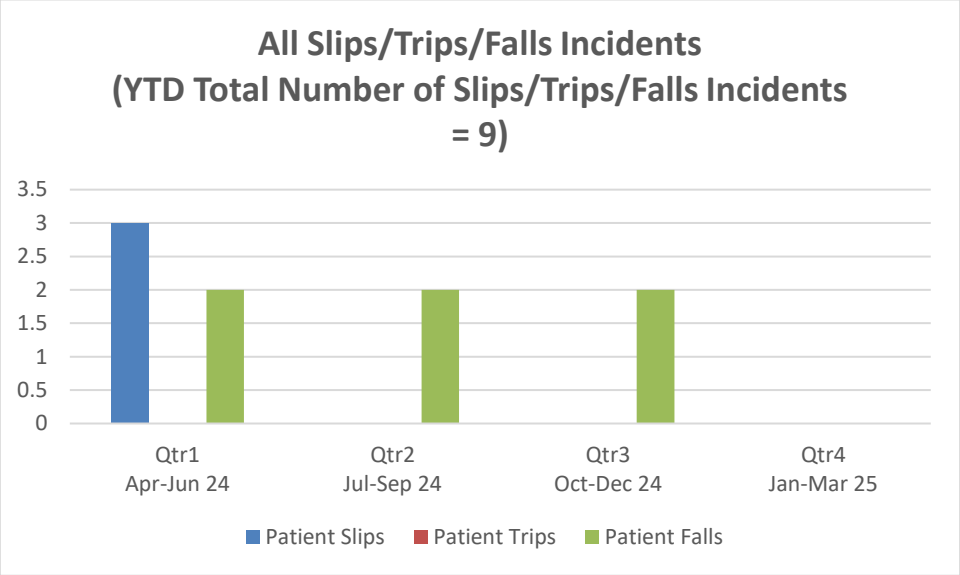
Our Data 2023/2024

Falls-

Following a review of fall incidents over the last 2 years there was a total of 17 patient incidents between 2023 and 2024. Due to a moderate harm incident this was identified as an area of focus during 2023 to 2024 and a detailed "After Action Review" and Falls Improvement Action Plan was developed; a falls thematic analysis was also completed. The thematic review identified with the hospice patient cohort a key theme was in maintaining independence and dignity.

During 2024 to 2025 (a 9 month period) our refreshed data shows a small decrease in the number of falls incidents, 9 in total.

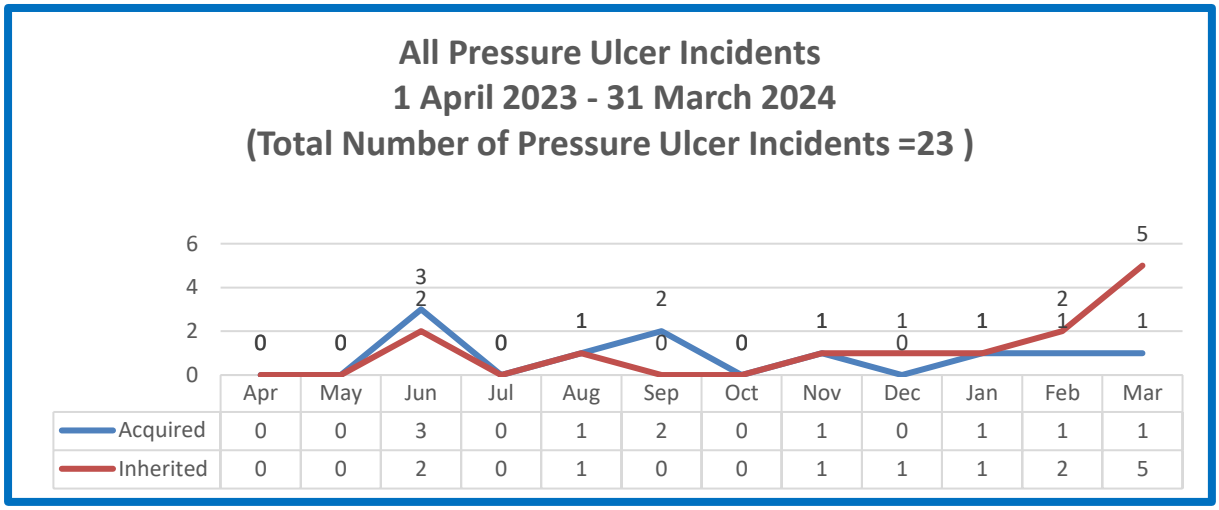




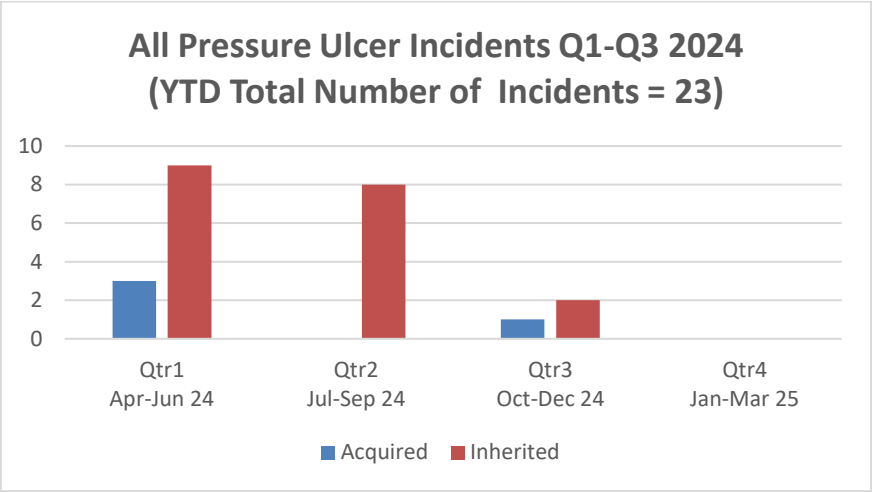
Therefore, the recommendation over the next 12-18 months is to support a local incident response for falls by completing an annual Thematic review for all falls. To be completed end of quarter four and presented the subsequent quarter one.

Pressure Ulcers-

Following a review of clinical incidents over the last 2 years there was a total of 10 acquired pressure ulcers from 2023 to 2024. During 2024 to 2025 (a 9 month period) a total of 4 acquired pressure ulcers have been identified. During the past 2 years the clinical team at St Rocco's has reviewed and developed reporting processes and embedding an open and transparent reporting culture and learning from patient safety incidents. A focus over the last 2 years on tissue viability training, development of a tissue viability link nurse and a working relationship with our community tissue viability nurse to support understanding of our patient population and changes to tissue visibility as part of end of life care when approaching last hours/days of life, has seen an impact in patient harm.



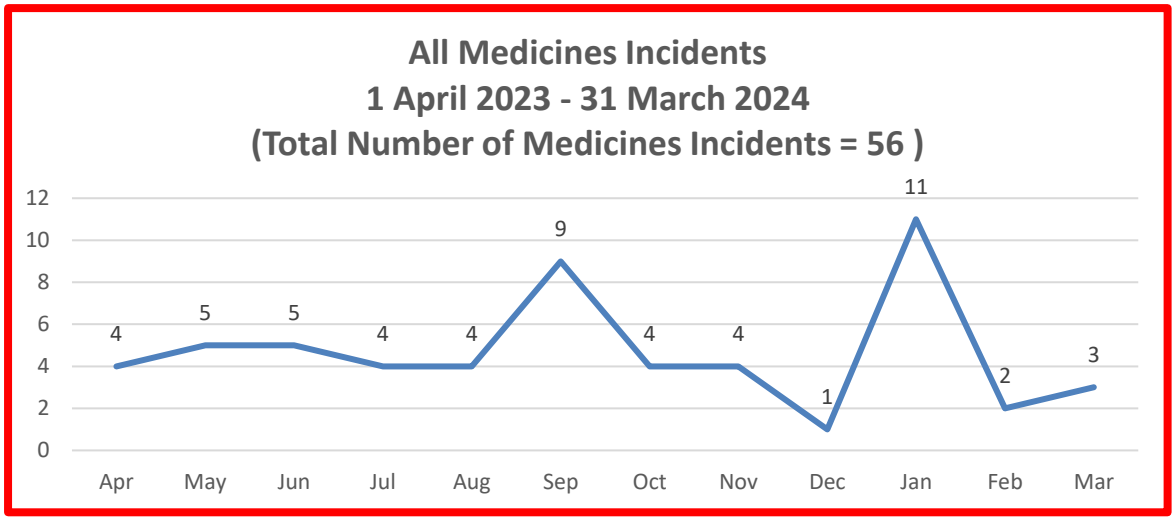
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Acquired	0	0	3	0	1	2	0	1	0	1	1	1
Inherited	0	0	2	0	1	0	0	1	1	1	2	5

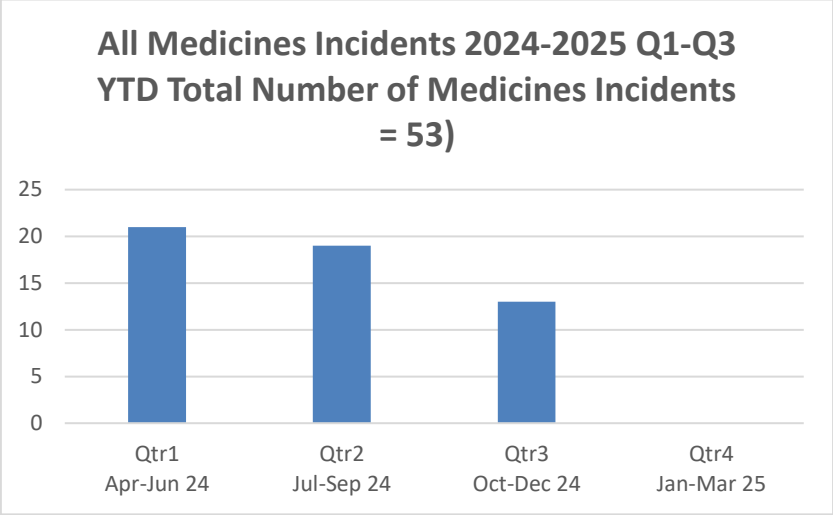


Therefore, the recommendation over the next 12-18 months is to support a local incident response for acquired pressure ulcers deteriorating category 2 pressure ulcers for non-end of life patients through a “After Action Review”.

Medication Incidents-

Following a review of clinical incidents over the last 2 years there was a total 56 medication related incidents during 2023 to 2024. During 2024 to 2025 (a 9 month period) a total of 53 medication incidents have been reported.





Electronic and Prescribing Medicines Administration (EPMA) was launched on the 23rd of April 2023. An initial business case was approved in 2019, following an identified trend of medication incidents due to omission, however, due to the covid-pandemic the implementation of EPMA was postponed until April 2023.

Over the course of the last 18 months the clinical team, with support from system support staff have worked to ensure all staff are trained and skilled in the use of the system. The system is now embedded and August 2024 an evaluation was undertaken to start to focus on understanding the impact on prescribing and administration processes and identify early learning.

Led by our incident trend analysis, with a goal to reduce incidents/harm levels associated with medicine prescribing and administration practices, the evaluation was focused on four criteria:

1. Prescribing off formulary: to work to optimize the systems safe prescribing capacity through the selection of default options as opposed to a free text approach.
2. Medication queries and timing of actions: recognized as an example of good communication practice.
3. Unconfirmed medication: to confirm that medication administration is fully completed, recorded and saved.
4. Current prescribing history is accessed as part of the first assessment: to ensure that continuity of prescribing history is maintained.

The evaluation was undertaken during August 1st-31st 2024. During the period all medication episodes were included in the evaluation. The evaluation was undertaken by an external partner as it was recognised that as part of the implementation process, we had not developed the internal capability to extract system data.

The expertise of the external provider at this stage was recognised to also add additional value due to previous experiences of EPMA implementation at neighboring hospices. The data generated was then jointly analysed by the external provider and senior clinical team. During this period of evaluation, no omissions were identified, and acknowledged the system prompt as part of EPMA to identify early any medication not administered, the short period of time, evaluation for one month, was noted.

To further understand medication incidents and taking into consideration the areas of patient safety and quality improvement currently in place, the local response plan will focus on medication incidents following omission of controlled drugs and complete an “After Action Review” as part of the learning response.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Reducing Falls (1 x learning response annually)	Incidents reported through vantage incident reporting module and monitored for increase and any trends. A **Thematic Review** will be completed annually.	Learning and improvement identified, developed and shared as part of learning and incident review process; Senior clinical team and Quality and Safety subcommittee. Continuous improvement cycle, incident trends, planned clinical audits and planned training.
Reducing Pressure Ulcers Deteriorating Acquired Category 2 pressure ulcer (not end of life care) (Predicted approximately 4-5 learning responses per year)	Incidents reported through vantage incident reporting module and monitored for increase and any trends. Where identified for patients who are not end of life (within the last hours/days of life) deteriorating Acquired Category 2 pressure ulcer to complete an **After Action Review**.	Learning and improvement identified, developed and shared as part of learning and incident review process; Senior clinical team and Quality and Safety subcommittee. Continuous improvement cycle, incident trends, planned clinical audits and planned training.
Reducing Medication Incidents	Incidents reported through vantage incident reporting module and monitored for increase and any trends.	Actions will be presented and reviewed under Quality and Safety Subcommittee, reported to Board and CQPG.

Omission of medication (controlled drug) (Predicted approximately 4-5 learning responses per year)	Where identified for **omission of medication involving a controlled drug** an **After-Action Review** will be completed.	Learning will be shared internally within the hospice and with partners.

PSIIs and LFPSE

Once St Rocco's is operating under PSIRF and using V6 of the taxonomy (containing the learning response fields), all response data for new safety events submitted by providers will be accessed via LFPSE. ICBs and NHS England regional teams will no longer need to access StEIS to see information about new PSIIs submitted by providers who are operating under PSIRF. Safety events already recorded to StEIS can continue to be monitored via StEIS.

The Chief Operating Officer and Clinical Lead will have responsibility for consideration of incidents for PSII and reporting via LFPSE. The Chief Operating Officer will have overall oversight of the outcomes of such reviews to ensure recommendations are founded on a system-based approach and safety actions contribute to safety improvement plans. Progress of quality and safety improvement plans will be reported quarterly at Quality and safety sub-committee where the Chief Operating Officer and designated trustees will have oversight of processes and will challenge decision making of the senior clinical team to ensure the board can be assured that the true intent of PSIRF is being implemented.

Local level incidents – managers of all clinical areas must have arrangements in place to ensure that incidents can be reported and responded to. Incident responses should include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until further review is possible. This may include for example, withdrawing equipment or monitoring response. Any response to an incident should be fed back to those involved or affected and appropriate support offered. Where Duty of Candour applies this must be carried out according to hospice guidance.

Incidents with positive or unclear potential for PSII – all staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event through internal escalation processes and this must include their immediate line manager. Duty of Candour disclosure should take place according to hospice guidance. Where it is clear that a PSII is required the clinical manager allocated to investigate from the raised incident should notify the Chief Operating Officer and Clinical Lead as soon as practicable so that the incident can be shared to the Clinical Leadership Team and then escalated to the Senior Clinical team. A rapid review will be undertaken by the Chief Operating Officer or Clinical Lead to inform decision making at the Clinical Leadership Team and onward escalation following this.

Other incidents with unclear potential for PSII, must also be reported to the Chief Operating Officer and Clinical Lead. The hospice Senior Clinical Leadership Team will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning any mitigation identified by the rapid review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The group will define terms of reference for a PSII to be undertaken by the response lead. The group will also designate subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared. Where an incident does not meet the requirement for PSII, investigations will be undertaken in accordance with patient safety response plan. The Clinical Leadership Team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the Care Quality Commission according to accepted reporting requirements.

The Quality and Safety Sub-committee will oversee the operation and decision-making of the senior clinical team.

Where required the hospice will work together with partners to establish and maintain robust process to facilitate free flow of information and reduce delays to joint working on cross-system incidents. The hospice has strong working relationships with the 2 key health organisations at place, Warrington and Halton Foundation Teaching Hospital and community provider Bridgewater Community Healthcare Foundation Trust and has developed a process for shared information as part of the LFPSE reporting (Appendix B). Advice is sought from our ICB place patient safety lead where cross-system incident is felt to be complex or further support required to develop robust processes.

Timeframes for Learning Responses

Incidents are reported within 48 hours via the incident and risk management software Vantage. All clinical incidents are reviewed within one working day of reporting by the clinical lead, quality leads or ward manager. All clinical incidents are reviewed weekly (subject to leave) by the Chief Operating Officer and progress on incidents under investigation are reviewed weekly. Where possible all clinical incidents should be reviewed and actioned as soon as possible and actioned within one month. On exception incidents can be reviewed and actioned over a longer period, maximum three months, due to staffing absence or following a request to postpone from an external partner, or delay in information from an external partner.

Where a PSII for learning is indicated, the investigation must be started as soon as possible following identification of the patient safety incident. This investigation should be completed within one to three months, on exception this time period may be extended to support including if an external partner requests for this to be postponed or an external body delays information).

Safety action development and Monitoring Improvement

Following a patient safety incident and review or PSII will identify the circumstances an incident happened, but to reduce risk and improve patient safety actions need to be implemented. To present and share learning from incident responses to inform improvements and how safety actions can be monitored for against the hospice PSIRP all incidents' responses will be monitored through monthly clinical meeting and quarterly Quality and Safety sub-committee.

The hospice will develop clear documentation to include documented safety action plans to review and monitor implementation and progress. Where overarching systems issues are identified by learning responses outside of the hospice local priorities, a safety improvement plan will be developed.

The hospice has designated the Chief Operating Officer as the executive lead. The Chief Operating Officer, working with place patient safety lead and ICB, will oversee the development, review and approval of the hospice implementation of Patient Safety Strategy.

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.

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.

SJR - Structured judgement review
Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

SWARM - Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

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

SMART

SMART criteria are used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of 5 criteria or rules to help for the goal setting as follows

S- Specific – a goal should not be too broad but target a specific area for improvement

M- Measurable – a goal should include some indicator of how progress can be shown to have been made

A- Achievable – a goal should be able to be achieved within the available resources including any potential development needed

R- Relevant – a goal should be relevant to the nature of the issue for improvement

T- Time-related – a goal should specify when a result should be achieved or targets might slip

Appendix B

Contact Email Addresses

LFPSE guidance:

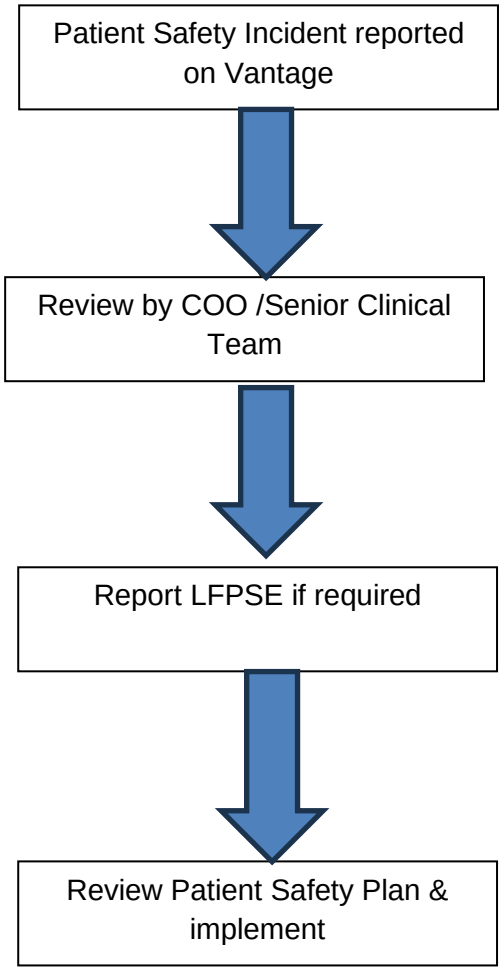
BCHFT- bchft.riskmanagementgeneral@nhs.net

WHHFT- nch-tr.WHHGovernance@nhs.net

Community pharmacy- cmpharmacyincidents@cheshireandmerseyside.nhs.uk

Appendix C

Patient Safety Incident Flowchart



Appendix D

Topic	Duration	Content	All Staff	Staff undertaking incident investigations	Patient Safety Specialist & Engagement Lead	PSIRF Oversight Role	Exec Leadership Team / Board
Patient safety syllabus level 1: Essentials of patient safety for all staff	e-learning 40 mins	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety	✓	✓	✓	✓	✓
Patient safety syllabus level 1: Essentials of patient safety for boards and senior leadership teams	e-learning 40 mins	• The human, organisational and financial costs of patient safety • The benefits of a framework for governance in patient safety • Understanding the need for proactive safety management and a focus on risk in addition to past harm • Key factors in leadership for patient safety • The harmful effects of safety incidents on staff at all levels				✓	✓
Patient safety syllabus level 2: Access to practice	e-learning 40 mins	• Introduction to systems thinking and risk expertise • Human factors • Safety culture		✓	✓	✓	
Oversight of learning from patient safety Incidents (HSSIB)	1 day/ 6 hours	• NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning				✓	
Systems Approach to Learning (HSSIB)	2 days / 12 hours	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews • Safety action development, measurement, and monitoring		✓			
Involving those affected by Patient Safety Incidents in the Learning Process (HSSIB)	1 day	• Duty of Candour • Just culture • Being open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support			✓		
Continuing professional development (CPD)	At least annually	• To stay up to date with best practice (eg through conferences, webinars, etc) • Contribute to a minimum of two learning responses		✓	✓	✓	