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OPTICIANS | HEARING CARE

Scrivens Opticians and Hearing Care Patient Safety Incident Response Framework (PSIRF) Plan

Contents

1. Introduction

Scrivens Limited is committed to providing high-quality care, ensuring patient safety, and fostering a culture of continuous improvement. The Patient Safety Incident Response Framework (PSIRF) Plan outlines our approach to responding to and learning from patient safety incidents, enabling the identification and implementation of measures to prevent harm and improve care standards across our services.

The aims of a PSIRF plan are

1.1. Compassionate engagement and involvement of those affected by patient safety incidents.
1.2. Application of system based approaches to learning from patient safety incidents.
1.3. Considerate and proportionate responses to patient safety incidents.
1.4. Strengthening the response system functioning and continuous improvement.

2. Purpose of the Plan

The plan outlines the systematic approach to respond to patient safety incidents by establishing a clear process for incident detection, investigation, response and recovery. The goal of the plan is to protect patients from harm, learn from errors, prevent recurrence and promote a culture of safety through effective management, communication and response to patient safety incidents while continuously improving care delivery.

The objectives of the plan are:

2.1. To ensure the safety and wellbeing of patients and staff at all times.
2.2. To establish clear roles and responsibilities to respond to patient safety incidents.
2.3. To provide timely communication and support to patients, staff and their families in the event of a patient safety incident.
2.4. To ensure comprehensive analysis, reporting and learning from patient safety incidents.
2.5. To implement strategies for preventing future incidents.
2.6. To comply with legal, regulatory and accreditation standards for patient safety.

3. Types of Patient Safety Incidents

The plan applies to all patient safety incidents at all clinics including those related to,

3.1. Optical health (e.g. errors in prescription or diagnosis).
3.2. Hearing services (e.g. improper fitting of hearing aids or failure to identify hearing loss).
3.3. Interactions between staff and patients (e.g. communication issues, breaches of confidentiality).
3.4. Any incidents related to equipment malfunctions, clinical negligence, or adverse reactions to treatments.
3.5. Any adverse events and near misses.

4. Activation Procedure

4.1. **Triggering the PSIRF Plan:** It is initiated with any patient safety incident and not limited to,

4.1.1. Direct reports from clinical staff or patients

4.1.2. Incident reports filed by staff

4.1.3. Patient safety monitoring that has detected irregularities

4.1.4. Adverse event detection through audits or checks.

4.2. **Incident Classification:** They are categorised based on their severity and impact.

4.2.1. **Level 1 (Minor Incident):** They have minimal harm that can be managed locally. E.g.: Environmental issues that are temporary in nature and do not cause harm (power failure, leaks, etc.) or minor injuries from non-recurring circumstances.

4.2.2. **Level 2 (Moderate Incident):** Incidents that require investigation and may require corrective actions with reviews and monitoring. E.g.: Incidents that cause intermittent disruption to the service, such as large scale equipment failure or result in non-life threatening or life changing injury from non-recurring circumstances.

4.2.3. **Level 3 (Severe Incident):** They result in significant harm with long-term consequences and require extensive intervention. E.g.: Misdiagnosis of a condition or serious injury from accident with long-term consequences.

4.3. **Response Structure:** It is established based upon the established roles and responsibilities of individuals during a patient safety incident.

Patient Safety Incident Team: It is a multi-disciplinary group that works together to review incidents that have been reported or detected. It is the duty of the team to assess the root cause of the incident, determine corrective action and recommend improvements. The members are,

4.3.1. **Safeguarding Lead:** Leads the response, coordinates with other departments and ensures safety protocols are being followed.

4.3.2. **Patient Safety Specialist:** Works with departments to ensure that patient safety incident responsibilities meet legal and regulatory requirements and that continual improvement is maintained.

4.3.3. **Customer Services Manager:** Individual who communicates with patients, families and internal teams to ensure that accurate and up to date information is being shared.

4.3.4. **HR Manager:** Individual who communicates with staff members and internal departments to ensure that company policies and procedures are being followed.

4.3.5. **E-Learning Manager:** Ensures that the safety policies are updated and followed regularly, incidents are documented and risk assessments are undertaken regularly.

The group may also include the following if required:

4.3.6. **Clinical Lead:** Senior clinician who oversees the clinical aspects of the response including patient care and treatment.

4.3.7. **Health and Safety Manager:** Individual who manages all clinical and administrative spaces to ensure that they meet all clinical, regulatory and legal requirements.

5. Phases of the Response

5.1. Detection and Initial Response:

5.1.1. Immediate action: Upon identifying an incident, immediate steps are taken to protect the patient, mitigate further harm and stabilise the situation.

5.1.2. Patient Safety Incident Review: An initial quick review of the patient's clinical status and ensure corrective treatment is provided.

5.1.3. Documentation: Document accurately regarding the incident, treatment steps and actions taken.

5.2. Investigation and Root Cause Analysis (RCA):

5.2.1. Root Cause Analysis (RCA): Investigate the factors that contributed to the incident using RCA, Failure Mode and Effects Analysis (FMEA) or other safety investigation frameworks.

5.2.2. Data Collection: Gather relevant data including medical records, staff testimonies and environmental factors.

5.2.3. Patient Impact Assessment: Evaluate the extent of harm caused, including physical, psychological and emotional.

5.2.4. Interviews and Surveys: Conduct interviews with involved personnel and where appropriate, patients and families to understand contributing factors.

5.3. Communication: All communication should be clear and transparent.

5.3.1. Patient and Family: Immediately notify the patient and their family about the incident, providing details on what happened, the potential impact and steps being taken to resolve the issue.

5.3.2. Staff: Inform all relevant staff about the incident and its outcomes ensuring that they are aware of changes or improvements in patient safety protocol.

5.3.3. Public Reporting: Report incidents to external bodies such as regulatory agencies and network organisations.

5.4. Corrective Actions and Preventative Measures:

5.4.1. Corrective Actions: Develop and implement corrective actions based on the findings of the incident investigation. This includes process changes, staff retraining or changes in policies and procedures.

5.4.2. Preventative measures: Identify strategies to prevent the recurrence of similar incidents. This may include implementing new safety protocols, enhancing staff training as well as improving communication systems.

5.4.3. Monitoring and follow – up: Monitor the implementation of the corrective actions to ensure their effectiveness and ensure the change leads to improved safety.

5.5. Recovery and Support:

5.5.1. Patient Recovery Support: Provide support to the patient and family during the recovery process, ensuring appropriate follow up care and support.

5.5.2. Staff support: Offer psychological and emotional support to staff involved in the incident including counselling and peer support.

5.5.3. **System review and Update:** Review safety protocols and update practices based on lessons learned from the incident.

5.6. **Training and Education:**

5.6.1. **Regular Training:** Staff members including clinicians, nurses and admin personnel must undergo regular training on patient safety, reporting procedures and risk management.

5.6.2. **Post-Incident Learning:** Hold debriefings after significant incidents to discuss what went wrong, what worked well and how to prevent future incidents.

5.7. **Monitoring, Evaluation and Continuous Improvement:**

5.7.1. **Incident Reporting Systems:** Encourage a non-punitive culture of incident reporting where all incidents including near misses should be reported and analysed.

5.7.2. **Ongoing Monitoring:** Continuous monitoring for potential safety risks and tracking the effectiveness of corrective and preventative actions.

5.7.3. **Evaluation and feedback:** Use feedback from patients, families and staff to improve practices. It includes regularly evaluating the effectiveness of the PSIRF Plan and revising it as needed.

5.7.4. **Safety Audits:** Regularly conduct safety audits – clinical, safeguarding as well as physical to identify any risks or gaps in PSIs.

5.8. **Compliance and Legal Considerations:**

5.8.1. **Regulatory Compliance:** Ensure that the PSIRF plan complies with local and national guidelines, regulations and standards.

5.8.2. **Legal Documentation:** Maintain appropriate documentation and evidence of the response to ensure compliance with legal and accreditation requirements.

5.8.3. **Confidentiality:** Maintain confidentiality and adhere to privacy laws when handling incident reports.

6. Risks of PSIRF

Key risks associated with the implementation of PSIRP include:

6.1. **Staff capacity and training gaps:** Risk of inadequate response due to insufficient training.

6.2. **Cultural resistance:** Risk of non-reporting if staff fear repercussions.

6.3. **Resource limitations:** Financial and operational constraints affecting timely incident response.

6.4. **Maintaining Process Effectiveness:** Due to the general low risk nature of the services involved, the potential lack of patient safety incidents may result in the infrequent use of one or more mechanisms of this process, leading to diminished effectiveness through the lack of use.

Mitigation includes focused training, clear communication of just culture principles, and resource allocation.

7. Associated policies

All associated policies that protect patients and staff and ensure safe and equitable access to care are listed below.

- Equality & Diversity policy
- Safeguarding Children and Adults policy
- Duty of Candour policy
- Incident & Near Miss Management and Reporting policy
- Access to Care and Transfer of Care policy
- Complaints policy
- Confidentiality and data protection policy
- Information Security policy
- Record Management policy