scrivens
OPTICIANS | HEARING CARE

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

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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) Policy 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.

2. Purpose of the Policy

The purpose of this policy is to ensure a systematic approach to responding to patient safety incidents at Scrivens Limited. It also determines responsible persons, sets out processes and procedures for identifying, managing and responding to safety incidents. The aim is to ensure safety of patients and staff, minimise harm and/or recurrence and facilitate continuous improvement in service provision by implementing proactive risk management and response to while continuing to learn from incidents. The key objectives include:

2.1. Ensuring the safety and well-being of patients and staff is prioritised and maintained at all times.

2.2. Providing a structured framework to respond to and manage patient safety incidents.

2.3. Encourage reporting of all types on incidents including near misses without fear of punitive actions.

2.4. Investigating incidents to determine root causes and implement corrective actions to prevent and reduce recurrence.

2.5. Complying with relevant health and safety regulations (e.g. NHS regulations, NICE, GOC, HCPC, Government, IQIPS, etc.).

2.6. Maintaining public confidence in the quality and safety of services provided by fostering transparency and continuous learning within the organisation.

There are many ways we can respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement and there is no remit to apportion blame or determine liability, preventability or cause in a response conducted for the purpose of learning and improvement. Responses are conducted for the sole purpose of learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence.

Responses are insulated from remits that seek to determine avoidability, preventability, predictability, legal liability, blame, professional conduct, competence, fitness to practise or Criminality. Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroner's inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

3. Scope

This plan applies all areas of the service including clinical, administrative and support staff involved in the management and responding to of safety incidents occurring at Scrivens Limited's 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.

4. Our Services

Scrivens Limited is a provider of:

4.1. Hearing care: offering audiology assessments, hearing aids, and specialist advice.

4.2. Optometry services: including eye examinations, prescriptions, and eyewear.

4.3. Occupational health services: ensuring employee well-being through health surveillance and assessments.

5. Our Locations

Scrivens operates across a range of locations, including:

5.1. Hearing and eye care centres in major towns and cities.

5.2. Community-based service points.

5.3. Partnerships with primary care, hospitals, trusts, and other healthcare providers.

All sections within this PSIRF policy will apply equally across all locations regardless of their circumstances.

6. Definitions

6.1. **Patient Safety Incident:** Any unintended or unexpected incident that could or did lead to harm for a patient receiving care.

6.2. **Adverse event:** Harm, Injury, suffering, disability, or death caused by exposure to healthcare services. A patient safety incident that results in substantial harm, death or significant risk to patients.

6.3. **Near Miss:** An incident that could have caused harm but did not, either by chance or timely intervention.

6.4. **Never Event:** Are incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

6.5. **Duty of Candour**: A statutory duty to be open and honest with patients when something goes wrong with their care and treatment, and to inform them of the actions taken to mitigate further risks.

6.6. **Just Culture:** A culture that seeks to balance accountability and learning when responding to incidents.

6.7. **Non conformity:** An issue, that whilst not sufficient in presentation to qualify as an incident, with appropriate quantity may indicate a pattern of potential risk and/or improvement.

6.8. **National and Regulatory Incident:** Are patient safety Incidents that require a specific type of response as set out in national policies or regulations. These responses will include an internal investigation or review by the appropriate team, based on the nature of the Incident.

6.9. **Root Cause Analysis (RCA):** To examine, study or inquire into an incident, event or process systematically. Any investigation undertaken at Scrivens has the aim of examining the system and not individuals. This includes what works well and where there are potential safety gaps to a system or process.

6.10. **Corrective and Preventative Actions (CAPA):** Actions undertaken to correct he immediate cause of an incident and to prevent future recurrence.

6.11. **Patient Safety Network:** Clinical partners who facilitate shared learning and improvement.

6.12. **Patient Safety Partner:** Patient partners who facilitate shared learning and improvement.

7. Key Responsibilities

7.1. **Safeguarding Lead:** Overall responsibility for the implementation and oversight of this plan. The lead coordinates investigations, reporting, and communication with regulatory bodies.

7.2. **Patient Safety Specialist:** Responsible for the implementation of PSIRF across Scrivens Ltd and leads the response and investigation into patient safety incidents.

7.3. **Patient Safety Incident response team:** Representatives from different areas of the organisation – clinical, administrative, quality assurance, patient management, staff management and risk management respond to and investigate the incidents, determine causes and suggest corrective actions.

7.4. **Clinic Leads:** To conduct routine audits as agreed intervals and investigate all relevant reports from other parties, engaging with other key stake holders as required.

7.5. **Clinicians (Optometrists/Audiologists**): Report incidents, assist in investigation processes, and participate in reviews of procedures and patient safety improvements.

7.6. **All Staff**: Report all patient safety incidents, participate in incident reviews, and comply with corrective actions.

7.7. **Senior Management:** Oversee resource allocation for implementing safety measures and supporting corrective actions.

8. Data Sources

Data on patient safety incidents are gathered from multiple sources, including:

8.1. **Internal reporting systems:** Incident logs and reports filed by staff on The Operations Manual (TOM) system, in line with our incident reporting procedure.

8.2. **Patient feedback and complaints:** Surveys and verbal reports. This could be via feedback collection points (follow-up contacts, aftercare questionnaires etc.) and recorded within our clinical systems or patient responses recorded within our patient feedback system.

8.3. **Professional bodies:** Guidance from the professional bodies, including the British Society of Audiology (BSA), British Academy of Audiology (BAA), General Optical Council (GOC)

8.4. **Regulatory bodies:** Feedback from bodies such as the Care Quality Commission (CQC), UKAS under the Improving Quality in Physiological Services (IQIPS) service, The Health and Care Professions Council (HCPC)and NHS England.

8.5. **Representation bodies:** Advice from support bodies such as The Association for Eyecare Providers (FODO), The Association for Primary Care Audiology (NCHA) and The Optical Consumer Complaints Service (OCCS).

8.6. **National incident reporting systems:** For patient safety incidents, the Learn from patient safety events (LFPSE) service is referenced.

8.7. **Staff:** General staff reports and feedback.

8.8. **External:** Reports from NHS stakeholders, including the ICB, PALS, Primary Care and Trusts.

8.9. **Audit:** Clinical audit outcomes and reviews.

9. Incident Investigation Process

All incidents will be investigated promptly to establish the root cause and prevent recurrence.

This includes:

9.1. Incident Reporting and Detection:

9.1.1. All patient safety incidents including near missed and non-conformities must be reported through the designated centralised incident reporting system, TOM.

9.1.2. All incidents should be reported immediately and upon identification and without fear.

9.1.3. In addition to reporting, patient safety incidents should be detected through audits, patient feedback, safety monitoring systems, etc.

9.2. Immediate Response:

9.2.1. Immediate action should be taken to minimise further harm to the patient. It may include providing emergency care, ensuring patient safety, notifying relevant departments and isolating or mitigating potential risks.

9.3. Investigation and Root Cause Analysis:

9.3.1. **Immediate review:** The Safeguarding Lead will conduct an initial review with the appropriate Clinical Lead to determine the severity and gather information.

9.3.2. **Root Cause Analysis (RCA):** An RCA should include a detailed review of the incident with in depth interviews with involved staff, and feedback will be taken from key stakeholders to investigate and identify contributing factors that can include human error, system failures, environmental factors, equipment malfunctions or gaps in policies, procedures or training.

9.4. Corrective and Preventative Actions:

9.4.1. **Implement corrective measures:** This could include changes in procedures, retraining staff, purchasing new equipment or reassigning responsibilities.

9.4.2. **Preventative actions:** It includes taking actions to address systemic issues identified during RCA to reduce likelihood of similar incidents. It includes revising safety protocols, implementing additional safeguards or redesigning workflows to improve efficiency and safety.

9.4.3. **Training and Education:** All staff will be trained in reporting and response procedures. Training will be ongoing and tailored to specific roles where necessary. Annual refresher courses are mandatory.

9.5. Monitoring and follow-up:

9.5.1. Effectiveness of the corrective and preventative actions are continuously monitored with the option to include follow up assessments and audits to ensure efficacy.

10. Communication and Transparency

10.1. Internal:

In line with the Duty of Candour, patients and their families should be informed of the incident as soon as it is appropriate. Timely communication should be provided to all involved as well as relevant staff.

They should be provided clear and honest explanations of what happened, how the incident will be investigated, and any actions being taken to address it.

10.2. External:

Incidents that meet regulatory legal reporting requirements must be communicated to relevant authorities. E.g.: NHS bodies, accreditation bodies, professional bodies, regulatory bodies, representation bodies, incident reporting bodies, etc. and if need arises, public entities like the police, etc.

11. Documentation and Recording

All incidents are tracked using a patient safety management system that records the type, severity and outcome of each incident. Trends and patterns in incidents will be regularly reviewed to identify areas for improvement.

12. Ensuring Continuous Improvement

Scrivens Ltd will continually evaluate the effectiveness of the PSIRF policy through regular audits, incident reviews and performance assessments. Lessons learned from patient safety incidents are incorporated into policies, training and safety protocols to enhance the company's safety culture.

The Patient Safety Incident response team engage on a six monthly cycle with the express purpose of reviewing clinical, safeguarding or health and safety information and provided shared learning for the purpose of ensuring continued improvement within the service.

This may also include input from additional stakeholders in the event of specific learning requirements need to be facilitated to ensure improvement.

All information relating to these meetings will be provided to the Safeguarding Lead to support wider improvements as required.

13. Risks of PSIRF

Key risks associated with the implementation of PSIRP include:

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

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

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

13.4. **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.

14. 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