Lakeside Medical Diagnostics

Lakeside Medical Diagnostics Ltd

Patient Safety Incident Response Policy

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Patient Safety Incident Response Policy

Policy Statement

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Lakeside Medical Diagnostics Ltd.'s (LMDS) 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 is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under this contract.

The PSIRF advocates a coordinated 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 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.

Policy Principles

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all NHS Standard Contracts held by LMDS.

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.

Our Patient Safety Culture

LMDS are committed to:

- Fostering a just culture where our values of openness, honesty and non-judgemental are key.
- Promoting the focus of incidents on the system of working in order to learn lessons.
- Having honest conversations with key partners and openly reporting on incidents as part of contract requirements.

System Partners in Patient Safety

LMDS will continue to engage with key partners on a regular basis, via contract compliance meetings, progress reviews and ad hoc conversations. Where an incident is reported by LMDS which involves multiple providers across the local system, LMDS will discuss with the appropriate safety lead within the ICB concerned.

Addressing Health Inequalities

LMDS will apply a flexible approach and intelligent use of data to help identify any disproportionate risk to patients. We will respond to any issues relating to health inequalities as part of the implementation of this policy.

All staff will be guided by LMDS Incident and Accident Policy when managing an incident and ensure that the patient, and families and carers as appropriate, are kept at the centre of the process. The Incident and Accident Policy clearly lays out the process in a step-by-step format and starts with ensuring the person who is involved is safe and receives the necessary attention needed.
An incident log must be completed when the incident occurs, including witness statements, and the incident will need to be added to LMDS Incident and Accident Log, clearly stating what happened, the risk rating of the incident, mitigation, and actions along with who is responsible.

In the case of a significant incident (typically of moderate or greater harm), the CEO must be informed within 12 hours and an action plan will be completed in conjunction with the CEO, Health & Safety Manager and Head of Service Operations.

This will form part of discussions as to decide the most proportionate investigation including who will lead this if required. Details of this incident will be shared with the appropriate ICB who can provide support as required.

The national framework defines a number of national priorities which we must investigate locally through an in-depth investigation, called a patient safety incident investigation (PSII). LMDS report on incidents and events as part of contractual reporting and meetings with the relevant Integrated Care Board (Mid and South Essex ICB). In the event of an in-depth investigation being required, this will be done in collaboration with the appropriate ICB.

Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident

The PSIRF recognises that learning and improvement, following a patient safety incident, can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff).
This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. Those affected include staff and families in the broadest sense; that is: the individual, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred. LMDS will involve patients and families affected by significant incidents to ensure they are informed and any questions they have are answered as part of the investigation.

The Duty of Candour is a legal duty which ensures that patients (or their families) are informed when things go wrong in healthcare. It applies to unintended or unexpected incidents which result in moderate harm, severe harm or death. This includes receiving an apology, and sharing the investigation findings and actions to prevent recurrence. LMDS hold this responsibility, with the Clinical Lead as the named Duty of Candour.

It is important to recognise that patient safety incidents can have a significant impact on staff who were involved in or who may have witnessed the incident. Like patients and families they will want to know what happened and why and what can be done to prevent the incident happening again. Staff involved in patient safety incidents will have the opportunity to access professional advice from LMDS Employee Assistance Scheme and will be fully supported by LMDS throughout this period.

Patient Safety Incident Planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and

subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve.

LMDS aims to take a proportionate approach to the PSIRF, we will do this by:

- Resources and Training to Support PSIRF
  - LMDS will continue to work with key partners in ensuring we respond to incidents in an appropriate way according to guidance within the NHS Patient Safety Learning Response Toolkit NHS England » Patient safety learning response toolkit
  - LMDS will continue to attend relevant PSIRF updates from Mid and South Essex ICB as well as the ICB.
- Patient Safety Incident Response Plan
  - Due to the low numbers of safety incidents currently reported by LMDS a Patient Safety Incident Response Plan is not deemed necessary.
  - LMDS will follow the Incident and Accident Policy as well as the Safeguarding Policy when responding to incidents.

Responding to Patient Safety Incidents

LMDS takes responsibility to ensure all incidents and near misses are reported as required in line with national reporting standards and NHS Contracts. For the purpose of this policy an incident or near miss is described as “an unintended or unexpected event which has the potential to cause harm”.

Complaints and Appeals

Anyone wishing to make a complaint relating to their involvement in an investigation should be done so following the LMDS Complaints Policy and Procedure.

Staff should also feel confident in reporting concerns and complaints and can do so by following the Whistleblowing Policy.

Responsibility/Accountability

Ultimate Responsibility held by: The Director
Responsibility for Dissemination held by: The Business Manager and all Line Managers

Compliance with Statutory Requirements

- Patient Safety Response Framework

Related Policies & Procedures

- Incident and Accident Reporting Policy
- Complaints Policy and Procedure
- Whistleblowing Policy
- Health & Safety Policy